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THE SHIFT TOWARD MANAGED CARE AND EMERGING LIABILITY CLAIMS ARISING FROM UTILIZATION MANAGEMENT AND FINANCIAL INCENTIVE ARRANGEMENTS BETWEEN HEALTH CARE PROVIDERS AND PAYERS

*Brian P. Battaglia**

All these years, [providers] have been concerned with fighting socialized medicine, and now they've been blind-sided by capitalism.¹

I. INTRODUCTION

The entire system of managed care ("managed care" or "managed competition") has again come under attack due to recently publicized lawsuits and incidents focusing on injuries and deaths resulting from decisions that limited or denied medical care to patients. In light of these events, consumers of health care and the media have questioned whether such decisions were undertaken with the patient's best interests in mind or merely for the purpose of saving another health care dollar.

As a result of these concerns, it is imperative that consumers, the media, and health care professionals understand the factors which necessitated the transformation of health care delivery and provider reimbursement toward managed care and competition. The courts, deciding cost containment liability claims, must well understand events leading up to the present metamorphosis in the delivery of health care, and the critical part cost containment and financial risk shifting play in the managed care formula. With such knowledge, courts will be better suited to render legal decisions that can chart a course for providers, utilization managers, and legal professionals, who must navigate the newly discovered managed care liability waters. Such decisions will provide much needed guidance as to when and under what circumstances, cost containment mechanisms become instruments simply to enhance the provider's bottom line to the detriment of the consumer.

Managed care and managed competition are relatively new terms in health care terminology. Therefore, much of the confusion and doubt as to what these systems entail is the result of the health care industry's failure to skillfully explain to the public terms relating to cost containment delivery systems, such as health maintenance organization (HMO), preferred provider organization (PPO), physician-hospital organization (PHO) or integrated delivery systems

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1. BETTY LEYERLE, *THE PRIVATE REGULATION OF AMERICAN HEALTH CARE* 3 (1994).

(IDS).² Simply defined, managed care is a framework for maintaining costs associated with the delivery of health care at acceptable levels through the use of systems, such as HMOs and PPOs.³ In order to control costs, alternative delivery systems put in place policies which are intended to avoid unwarranted medical care. In addition, procedures such as pre-admission certification, concurrent review, discharge planning, case management, and utilization management are also relied upon as cost control measures.⁴

Managed competition, on the other hand, relies upon market forces to shape health care delivery into an efficient and cost conscious system. Specifically, managed competition organizes employers, health plans, and individuals into large purchasing alliances which negotiate price with numerous payers upon terms that, in many instances, result in the provider bearing a portion of the financial risk in the delivery of care.⁵ Thus, providers must compete on price with other providers of health care in order to secure contracts which will provide patients and income. Importantly, as a result of risk shifting, once providers secure such contracts, it is often necessary for them to modify behavior so as to avoid the practice of defensive medicine or the prescription of needless, costly care.

Interestingly, managed care systems of today are, in many respects, the offspring of cooperatives and other alternative delivery systems, programs first implemented more than 50 years ago.⁶ Therefore, in order to understand why cost containment has seemingly been thrust upon America's health care system overnight, this paper will first outline for the reader the forces which slowed the growth of alternative health care delivery systems and how skyrocketing costs ultimately diverted the traditional system of fee for service onto the path of managed care. In retracing this history, it will become evident why evolving systems of managed care have become the standard bearer, and potentially, without significant government intervention, the last hope for reducing health care costs. Second, this paper will explain the distinctions between the various managed care and integrated delivery systems incorporating cost containment mechanisms, such as utilization management and financial incentive arrangements. Third, emerging cost containment liability claims with respect to utilization management and financial incentive arrangements between health care providers and payers, and the impact recent cases interpreting the

2. See *infra* notes 164-90 and accompanying text.

3. LEGAL MEDICINE 663 (3d ed. 1995).

4. *Id.*

5. *Id.*

6. These original pre-paid health care plans revolved around similar group characteristics such as employment, religion, and ethnic background. See Randolph E. Sarnacki, Comment, *Contractual Theories of Recovery in the HMO Provider-Subscriber Relationship: Prospective Litigation for Breach of Contract*, 36 BUFF. L. REV. 119, 120 n.3 (1987).

Employee Retirement Income Security Act of 1974 may have on these emerging claims will be outlined for the reader. In addressing emerging cost containment liability claims, this paper will discuss the steps managed care entities should take to reduce their exposure from such claims.

II. THE FALL OF TRADITIONAL HEALTH CARE: THE RISE OF MANAGED CARE

As will be detailed below, America's move toward industrialization not only provided private enterprise and entrepreneurial physicians the opportunity to increase the delivery of medical care to employers and citizens, but it also provided the incentive to develop new systems so that employers and citizens could pay for such care.

A. Development of Private Health Insurance

Any form of health insurance coverage in America was sparse, if existent, during the late nineteenth and early portions of the twentieth century.⁷ Most early insurance companies providing health benefits, usually went out of business in quick fashion.⁸ Toward the latter part of the nineteenth century, some companies began to offer coverage for certain diseases and disability coverage.⁹ However, as of around 1920, very few Americans had medical insurance.¹⁰ Even during this period, with respect to small but noticeable increases in health care costs, concerns arose. One study, conducted in 1918, revealed that 7.6% of the average total medical charge of \$48.41 went toward hospital services.¹¹

7. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 200-01, 235-89, 335-49 (1982). Although there were movements initiated by labor and social progressives in the early part of this century supporting government sponsored compulsory health insurance, the medical profession had strong objections to these plans. For the most part, compulsory insurance movements would gain momentum, surge, and, in most instances, trickle away.

Some form of debate, and in several instances, proposed legislation relating to a national insurance system has been seen in almost each administration since Woodrow Wilson's. In most instances, legislation was either defeated or significantly watered down, with the most recent coming in the Clinton administration with the defeat of the Health Security Act.

8. *Id.* at 241.

9. *Id.* Most of the plans were usually for the sole purpose of supplementing lost income as a result of a work related injury. *Id.*

10. *Id.* at 242.

11. *Id.* at 259. Costs associated with health care and its availability to citizens was a concern when the National Committee on the Costs of Medical Care was formed in 1926. Members of this committee consisted of individuals in the medical, public health, and social science fields. The committee's chairman, Dr. Ray L. Wilbur, served in the Hoover administration as Secretary of the Interior. Information obtained by the committee from surveys

However, by 1929 that figure had risen to 13%, with \$108.00 going toward hospital reimbursement.¹² And by 1934, 40% of the average family's medical bill was for hospital and in-patient related physician charges.¹³ Because of these increases, medical expenditures were no longer isolated to the wage earner, rather a greater proportion of families aggregate incomes were being impacted by health care costs.¹⁴

Unfortunately, the collapse of America's economy during the 1930's prevented many citizens from even considering medical care. Not only did the general population suffer from decreased medical care, physicians and hospitals had great difficulty surviving.¹⁵ By 1930, many hospital beds were empty and income had dropped significantly compared to what had been generated during the decade of the 1920's.¹⁶ In an effort to address these problems, hospitals would provide care to those individuals who were subscribers of newly developed prepaid hospital health care plans.¹⁷ These first hospital sponsored plans evolved into what later became known as Blue Cross plans.¹⁸ In light of the developments in health care payment mechanisms during the 1930's, private insurance companies saw a potential for profit and developed insurance products such as indemnity coverage which initially paid for hospital care. Later, coverage under these policies was expanded to pay for physician services.¹⁹ In response to private insurance carriers expansion into the market, Blue Shield plans developed coverage which paid for physician services as well.²⁰

taken from close to 9,000 families indicated that those families with the lowest incomes (less than \$1,200 annually) received more types of health care due to charity care than families with higher incomes, but overall each income segment failed to receive the amount of medical services necessary for good care. Interestingly, the committee endorsed pre-paid health plans as a cost effective way for providing health care to citizens. See *infra* note 43; *American Medical Ass'n v. United States*, 130 F.2d 233, 246-47 n.65 (D.C. Cir. 1942)(citation omitted).

12. STARR, *supra* note 7, at 259.

13. STARR, *supra* note 7, at 259.

14. STARR, *supra* note 7, at 260.

15. BARRY R. FURROW ET AL., *HEALTH LAW, CASES, MATERIALS AND PROBLEMS* 534 (2d ed. 1991).

16. Vernellia R. Randall, *Managed Care, Utilization Review and Financial Risk Shifting: Compensating Patients For Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 11 (1993) (noting that hospital receipts in the 1920s were as high as \$236.12 and dipped to \$59.26 by 1930. Occupancy rates went from 71.28% to 64.12%).

17. Randall, *supra* note 16, at 11. In 1929, Baylor University Hospital was one of the first, when for \$6 per person per year it provided a large group of school teachers with 21 days of hospital care. Randall, *supra* note 16, at 11.

18. Randall, *supra* note 16, at 11-12.

19. Randall, *supra* note 16, at 11-12.

20. Randall, *supra* note 16, at 11-12.

B. Early Forerunners of Managed Care

For companies that employed many workers or were in high health risk industries, proper health care delivery was necessary in order to maintain a healthy work force. In some instances, companies hired physicians to provide health care for their employees.²¹ Railroad companies were far ahead of any other businesses in the industrial sector in the provision of health care services to employees.²² Medical services were necessary as a result of the railroads rather high injury rates and the expansion of rail service to isolated areas in the western part of the country.²³ Physicians supplying medical services for employees of industry were often employed by the companies. Interestingly, in other instances, the physicians or hospitals contracted directly with a company which paid a set rate for each worker on a monthly basis.²⁴ From the viewpoint of the few physicians who saw the opportunity, a stable (and prepaid) group of patients could provide a reliable revenue stream. Organized medicine's response to these innovations introduced a theme which continues to this day, in one form or another.²⁵ The medical profession viewed company controlled medicine with suspicion and viciously attacked the entrepreneurial physicians who were creating cooperatives or entering into prepaid agreements with employee groups or employers.²⁶ For example, physicians such as Michael Shadid were attacked by the medical profession in the late 1920's for establishing medical cooperatives. Dr. Shadid established a medical cooperative for approximately 6000 farm families in and around Elk City, Oklahoma.²⁷ For his efforts, other physicians labeled him "unethical," attempted to revoke his license, and, ultimately, the local medical society deprived him of malpractice insurance.²⁸ A company doctor at Sears & Roebuck Company in Chicago resigned after the local medical society stripped him of his member-

21. STARR, *supra* note 7, at 200-01.

22. STARR, *supra* note 7, at 201 (noting that the textile, mining, and lumbering industries also provided medical care to their workers).

23. STARR, *supra* note 7, at 201.

24. STARR, *supra* note 7, at 202.

25. STARR, *supra* note 7, at 203. The medical profession's position has been that it is not proper to sell services to anyone but the patient. In addition, associations representing physicians took the position that to sell services to third party payers or related corporate practice would interfere with the physician's ethical obligation to the patient. See *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922, 926 (1st Cir. 1984) (citing Comment, *The American Medical Association: Power, Purpose, and Politics in Organized Medicine*, 63 YALE L.J. 938, 978-80 (1954) and American Medical Association, *Principles of Medical Ethics*, ch. 3, art. 5, § 4)).

26. STARR, *supra* note 7, at 203.

27. STARR, *supra* note 7, at 303.

28. STARR, *supra* note 7, at 303.

ship arguing that his reduced rate services to family members of employees was unethical, and in conflict with his colleagues in private practice.²⁹

In 1929, two physicians in Los Angeles contracted with a large group of employees with the city's water and power department. A short six years later, what had by then become known as the Ross-Loos Clinic was providing services to over 12,000 workers and their dependents.³⁰ Studies during this period indicated that medical costs for those employees contracting with Ross-Loos Clinic were approximately half of those incurred by similarly situated individuals not associated with Ross-Loos.³¹ Despite these positive figures, the founders of the Ross-Loos Clinic were thrown out of the local medical society.³² Such conduct was not limited to individual physicians or local medical societies. The American Medical Association (AMA) also objected to cooperative medicine. Originally founded in the late 1840's, the AMA was a powerful force to be reckoned with by the 1930's.³³ Not only did the AMA vocally object to such cost efficient practices, it undertook a campaign to stop activities it considered "unlicensed, unregulated health insurance and the corporate practice of medicine."³⁴

One of many such campaigns began as a result of the opening of the Group Health Association (GHA) in November of 1937. GHA was a not-for-profit cooperative association of government employees in Washington D.C.³⁵ GHA was in the business of arranging for the provision of medical care and hospitalization to its subscribers and their dependents on a risk sharing prepayment basis.³⁶ In order to provide reduced health care services, GHA collected monthly dues from its subscribers. These funds were in turn used to employ a medical staff which consisted of salaried general practitioners and

29. STARR, *supra* note 7, at 203.

30. STARR, *supra* note 7, at 301 (pointing out that the clinic was named after its founders, Dr. Donald Ross and Dr. H. Clifford Loos).

31. STARR, *supra* note 7, at 301. Interestingly, such prepaid group practices existed well before the Committee on the Cost of Medical Care expressed support for such plans in 1933. See THE CORPORATE TRANSFORMATION OF HEALTH CARE, PART I, ISSUES & DIRECTIONS 87 (J. Warren Salmon ed., 1990). In 1933, Dr. Sidney R. Garfield established a prepaid plan for construction workers who were building an aqueduct to provide water for Los Angeles, California. The workers paid a small fee from their wages for the medical coverage. Little did Dr. Garfield know, that a few short years later, he would be persuaded by Henry J. Kaiser to implement this group practice prepaid plan for workers building the Grand Coulee Dam. From these beginnings arose one of the pioneers in managed care: Kaiser Permanente. See HMO, vol. 136, no. 3, May-June 1995, at 94.

32. STARR, *supra* note 7, at 304.

33. STARR, *supra* note 7, at 90-91. In 1846, a convention was convened in New York for the purpose of creating a national medical association. STARR, *supra* note 7, at 90-91.

34. STARR, *supra* note 7, at 305.

35. United States v. American Medical Ass'n., 110 F.2d 703, 705-06 (D.C. Cir. 1940).

36. *Id.*

specialists who were engaged in a group practice under the guidance of a medical director.³⁷ As a result of GHA's conduct, the AMA, along with local medical societies, carried out a course of conduct intended to prevent GHA from securing and retaining the services of qualified physicians or using hospital facilities in the District of Columbia.³⁸ In part, the AMA and the local medical societies threatened disciplinary action against doctors who joined GHA or who consulted with GHA staff physicians. Hospitals were threatened with retaliation if GHA physicians were permitted to use their facilities.³⁹

The AMA and related parties' conduct did not escape the notice of the United States Department of Justice, which obtained indictments against the AMA and others for violations of federal anti-trust laws. The government alleged that the conduct carried out by the defendants was consistent with the AMA's previous pattern of conduct and policy of discouraging and suppressing group medical practices which operated on a risk sharing pre-payment basis.⁴⁰

The AMA, along with the other defendants moved to dismiss the indictment. The motions to dismiss were granted by the district court.⁴¹ The district court's decision was appealed by the government and reversed by the circuit court,⁴² and a trial was held. As a result of the anti-competitive conduct orchestrated by the AMA, the government obtained convictions which were later affirmed.⁴³ Ultimately, the United States Supreme Court reviewed the case, upholding the convictions of 1943.⁴⁴ The Supreme Court found that the AMA had violated the provisions of § 3 of the Sherman Act by conspiring with its members to restrain trade and commerce in the District of Columbia.⁴⁵ The Court indicated that one of the driving forces behind the AMA's concerted action against GHA was its efforts to proliferate the prevailing sentiment of AMA members that all physicians should practice independently (without government or any other interference) on a fee for service basis.⁴⁶

One would think that as a result of the high court's decision in 1943, programs similar to GHA's (essentially a staff model health maintenance organization) would have quickly expanded. However, several factors would delay the formal acceptance of alternative cost containment systems (ACCS's)

37. *Id.* at 706.

38. *Id.*

39. *Id.* at 706-07.

40. *Id.* at 711-12 (noting that the AMA's Bureau of Economics took a leading part in suppressing group medical practice plans).

41. *United States v. American Medical Ass'n*, 28 F. Supp. 752 (D. D.C. 1939).

42. 110 F.2d 703 (1940).

43. *American Medical Ass'n. v. United States*, 130 F.2d 233 (D.C. Cir. 1942).

44. *American Medical Ass'n. v. United States*, 317 U.S. 519 (1943).

45. *Id.* at 532.

46. *Id.*

for another 30 years.⁴⁷ First and foremost, physicians avoided ACCS's in that they were not willing to subject themselves to the wrath of the AMA or local medical societies, which as previously discussed, could lead to censure, and in some instances, professional discipline.⁴⁸ Second, state laws enacted at the behest of the medical profession permitted the development of ACCS's, but only as long as they were under the control of physicians or approved by local medical societies.⁴⁹

C. The Rise of the Medical Industrial Complex

As mentioned above, not only did private health care coverage begin to increase during the 1930's, developments during World War II lead to a greater incentive to provide health care.⁵⁰ The incentives for providing additional care arose out of Internal Revenue Service rulings in the early 1940's, rulings that tentatively indicated that health care benefits provided to employees by the employer were deductible.⁵¹ In addition, unions were permitted to negotiate with employers on issues such as health care, without violating the wage stabilization guidelines in effect during World War II.⁵² After the war, health insurance continued to expand and by 1950 it was a \$1 billion per year business. A short 15 years later it had become a \$8.7 billion per year business.⁵³

The significant involvement of the medical community in the war effort and the experiences from that effort also resulted in improvements to surgical technique and in-patient and out-patient hospital organization.⁵⁴ During the war, various military branches operated ambulatory facilities which provided care to dependents of military personnel.⁵⁵ Thus, greater effectiveness in distributing health care was yet another factor which led not only to the

47. See Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (1973) (codified as amended in scattered sections of 42 U.S.C.).

48. STARR, *supra* note 7, at 305.

49. *Id.* at 306. The corporate practice of medicine doctrine also prevented the development of ACCS's outside of the control or oversight of the medical profession.

50. ELI GINZBERG, *THE ROAD TO REFORM: THE FUTURE OF HEALTH CARE IN AMERICA* 62-63 (1994). By 1991, over 178 million Americans paid for their health care through private insurance plans at a cost of approximately \$222.4 billion. See 2 BARRY R. FURROW ET AL., *HEALTH LAW TREATISE*, vol. 2, p. 2 (1995).

51. GINZBERG, *supra* note 50, at 62.

52. GINZBERG, *supra* note 50, at 62. See *Inland Steel Co. v. NLRB*, 170 F.2d 247 (7th Cir. 1948), *cert. denied*, 336 U.S. 960 (1949).

53. KAREN DAVIS ET AL., *HEALTH CARE COST CONTAINMENT* 11 (1990).

54. GINZBERG, *supra* note 50, at 61.

55. GINZBERG, *supra* note 50, at 61.

increased demand for those services after the war, but also fueled Congress's willingness to continue funding for research.⁵⁶

The evidence suggests that during the first four decades of the twentieth century medicine in the private sector was evolving from a "caring" to a "curing" mode.⁵⁷ Patient records from major teaching hospitals during the early part of this century reveal that patient per diem costs were approximately \$5.00, which today would be about \$50.00. Comparing these figures to today's average cost of \$1,000.00 per diem at a teaching facility reflects the trend toward high maintenance (and cost) health care.⁵⁸ The coming together of the many interrelated and independent events, including increased government expenditures in medical research completed the "caring" to "curing" metamorphosis which also led to significant increases in health care expenditures.

As America's economy expanded after World War II, so did its appetite for health care services and coverage. The government continued to play an ever growing part in that expansion. In 1950, America spent approximately \$12 billion on health care. This amount represented 4.5% of the gross domestic product.⁵⁹ Between 1929 and 1950, spending on health care increased at a rate of less than \$400 million per year.⁶⁰ The reasons for such modest increases during this 20 year period can in some respects be attributed to America's economic problems resulting from the market collapse in 1929, limited government expenditures prior to the advent of World War II,⁶¹ and consumer accountability for health care costs.⁶²

Ironically, prior to the 1920's, government expenditures were for the most part limited to medical research which indirectly arose out of the specialization movement that began in the 1800's.⁶³ For the most part, government expendi

56. GINZBERG, *supra* note 50, at 61.

57. GINZBERG, *supra* note 50, at 61.

58. GINZBERG, *supra* note 50, at 61.

59. GINZBERG, *supra* note 50, at 60.

60. GINZBERG, *supra* note 50, at 60. In 1929, health care expenditures were \$3.66 billion or \$30 per capita. See STARR, *supra* note 7, at 262.

61. GINZBERG, *supra* note 50, at 60.

62. KEITH J. MUELLER, HEALTH CARE POLICY IN THE UNITED STATES 61-63 (1993). During the 1930s and 1940s, the consumer of health care services paid a large portion of medical costs out-of-pocket. In 1950, the consumer paid approximately 83% of charges incurred, with insurance paying 11.4%. By 1967, direct share of patient payments had decreased to 50% with the insurance side increasing to 29%. Statistics from the Health Care Financing Administration indicated that by 1990 out-of-pocket payments by the patient were only 20.4% of total health care expenditures. Payment by insurance represented 32.5% with a remainder reflecting government expenditures of 42% and other private payments of 4.9%. *Id.*

63. VERNON W. LIPPARD, A HALF-CENTURY OF AMERICAN MEDICAL EDUCATION: 1920-1970, 4-5 (1974); see LESTER S. KING, AMERICAN MEDICINE COMES OF AGE: 1840-1920, 88-93

tures for research were carried on in government owned facilities.⁶⁴ As a result of the depression and a shift in social priorities during the Roosevelt administration, government support for research increased.⁶⁵ In 1937, the National Institutes of Health (NIH) were authorized by Congress to establish a National Cancer Institute which was to perform independent research.⁶⁶ In addition, Congress permitted grants to be awarded to non-government researchers approved by the Public Health Service.⁶⁷ During and after the war, there was a focus on research and increases in funding. This is evident in a comparison of the NIH's budgets from 1947 to 1950. In three short years, NIH's research budget grew from \$4 million to \$46.3 million.⁶⁸ By 1951, total funds spent on research nationwide reached \$181 million.⁶⁹

Congress's post-war spending also reflected an increased demand for health services. In 1946, Congress passed the Hospital Survey and Construction Act (Hill-Burton) which authorized funds for the construction of hospitals across the country. During the next twenty-four years under Hill-Burton, the government appropriated \$3.7 billion toward hospital construction with \$9.1 billion in matching funds contributed by states and local governments.⁷⁰ Not only did increased government support lay a foundation for greater access to health care, such access also resulted in continued growth in private health insurance plans.⁷¹

In addition to the Hill-Burton Act, in 1946 Congress enacted public law 293, which created the Veteran's Administration's Department of Medicine and Surgery and authorized it to include (and pay for) medical residents in its

(1984).

64. STARR, *supra* note 7, at 340.

65. LIPPARD, *supra* note 63, at 73-74.

66. STARR, *supra* note 7, at 338-40. The NIH was originally organized as the Hygienic Laboratory in 1887. See LIPPARD, *supra* note 63, at 73.

67. STARR, *supra* note 7, at 340. The Public Health Service was created in two phases between 1902 and 1912 in an expansion of the Marine Hospital Service which was created in 1870. STARR, *supra* note 7, at 340.

68. M. Gregg Bloche, *Corporate Takeover of Teaching Hospitals*, 65 S. CAL. L. REV. 1035, 1046-47 (1992).

69. STARR, *supra* note 7, at 343.

70. STARR, *supra* note 7, at 348-50.

71. GINZBERG, *supra* note 50, at 64; MUELLER, *supra* note 62, at 61-63. Indemnity insurance coverage was the traditional method used in paying for health care. Under this system, the care was provided by the physician, and a bill was submitted to the insurance company for payment. If the insurance policy covered the procedure, the physician was paid on a fee-for-service basis. Typically, this meant that the physician, who determined the charge, was reimbursed in full. The fee-for-service system has been criticized for causing excessive utilization and a resulting increase in health care expenditures. See Deven C. McGraw, *Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients?*, 83 GEO. L.J. 1821, 1821-22 (1995).

hospitals.⁷² By 1948, sixty-eight veteran's hospitals had affiliated with fifty-eight medical schools with that number increasing to seventy-seven by 1965.⁷³ The NIH's budget, which as previously mentioned was \$46.3 million in 1950, had grown to \$400 million by 1960.⁷⁴ Slowdown of government funding was nowhere in sight. Not only had government funding for research increased, but government funding to increase the number of physicians in America loomed just over the horizon. In light of this unprecedented growth in funding, hospitals as well as physicians prospered, resulting in the dilution of the AMA's penchant for opposing third-party responsibility in the administration or payment of health care.⁷⁵ A projected shortage of medical professionals in America led to the publication of a report entitled *Physicians For a Growing America* in 1959.⁷⁶ As a result of that report, Congress enacted the Health Professions Educational Assistance Act of 1963 (HPEAA).⁷⁷ Under HPEAA, the federal government was to provide matching funds for the construction of medical schools and expansion of older facilities, including teaching hospitals. In addition, federal funds were provided to schools that were able to increase first year classes by five percent.⁷⁸

D. The Medicare Program and Spiraling Health Care Costs

The historical efforts designed to enhance access to and increase expenditures for health care paled in comparison to Congress's enactment of the Medicare and Medicaid programs in 1965.⁷⁹ In part enacted to provide security to the increasing number of retired elderly who had no health care coverage, the Medicare program was passed only after concessions were made to pacify lingering fears from medical professionals concerning possible interference in the provider-patient relationship and to appease those in the medical community who opposed the program.⁸⁰ These concessions included retention of the fee-for-service payment system based upon physicians' customary, prevailing, and reasonable rates for the practice area.⁸¹ Hospitals were also protected in that reimbursement was calculated on the basis of their

72. LIPPARD, *supra* note 63, at 70.

73. LIPPARD, *supra* note 63, at 70-72.

74. STARR, *supra* note 7, at 347.

75. ELI GINZBERG ET AL., *THE ECONOMICS OF MEDICAL EDUCATION* 2-3 (1993).

76. LIPPARD, *supra* note 63, at 117-20.

77. LIPPARD, *supra* note 63, at 118.

78. LIPPARD, *supra* note 63, at 118.

79. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (collectively referred to as the Medicare Program).

80. GINZBERG, *supra* note 50, at 68-69.

81. GINZBERG, *supra* note 50, at 68-69.

costs.⁸² These concessions led to a dramatic increase in health care expenditures, which later played a part in the move toward managed care.⁸³

In 1965, federal spending on health care was \$4.8 billion.⁸⁴ A few short years later, Congress took note of the rapid increase in health care costs due, in large part, to Medicare expenditures.⁸⁵ These increases were directly related to the formulas for payment discussed above, which were included in the Medicare legislation by Congress. These reimbursement methods, which were largely adopted by non-government payers, upset the difficult fiscal balancing act hospitals, physicians, patients, and payers had engaged in prior to the Medicare program.⁸⁶

A mere five years after the passage of the Medicare program, government expenditures for health care had risen 12 percent, with per capita expenditures increasing from \$198 in 1965 to \$334 in 1970.⁸⁷ Approximately \$64 billion was spent on health care in 1970.⁸⁸ The factors which caused such modest increases in health expenditures during the first half of the century ultimately set in motion a chain of events that resulted in health care expenditures escalating to such extremes during the last half of the century. Recognizing this increase, the chief executive officer of one company declared:

What are these health care guys doing to us? Can't they get their costs under control? We can't pass any more costs on to our customers. We're worried that further cost sharing by our employees will be unacceptable and will lead some to drop their health care altogether! We know that many dependents are not protected!⁸⁹

National health expenditures continued to escalate as referenced in the following chart:⁹⁰

82. GINZBERG, *supra* note 50, at 68-69.

83. The reimbursement system under the Medicare program rewarded those providers who increased utilization and expenditures on capital costs. GINZBERG, *supra* note 50, at 68-69.

84. GINZBERG, *supra* note 50, at 69-70.

85. ODIN W. ANDERSON, *HEALTH SERVICES IN THE UNITED STATES: A GROWTH ENTERPRISE SINCE 1875*, 201 (1985).

86. GINZBERG, *supra* note 50, at 75. Under Medicare, hospitals were reimbursed retrospectively, receiving payment for reasonable and necessary costs for patient care. As a result there was essentially no reason to operate efficiently. See DAVIS ET AL., *supra* note 53, at 15.

87. ANDERSON, *supra* note 85, at 201.

88. DAVIS, *supra* note 53, at 164.

89. DEAN C. CODDINGTON ET AL., *THE CRISIS IN HEALTH CARE: COST, CHOICES AND STRATEGIES* 5 (1991).

90. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *MEDICARE AND THE AMERICAN HEALTH CARE SYSTEM*, REPORT TO CONGRESS 16, 104th Cong. (1995) (source: Health Care Financing Administration, Office of The Actuary, and the Congressional Budget Office for Projections).

Year	Total Spending (In Billions)		Per Capita Spending	
	Nominal	Real	Nominal	Real
1980	\$251.10	\$452.70	\$1,068.00	\$1,926.00
1985	\$431.50	\$599.30	\$1,761.00	\$2,428.00
1990	\$696.60	\$790.90	\$2,684.00	\$3,048.00
1991	\$755.60	\$822.60	\$2,880.00	\$3,136.00
1992	\$820.30	\$867.10	\$3,094.00	\$3,271.00
1993	\$884.20	\$907.40	\$3,301.00	\$3,388.00
1994*	\$940.80	\$940.80	\$3,478.00	\$3,478.00
1995*	\$1,007.70	\$977.40	\$3,690.00	\$3,579.00

*Projections.

E. The Shift Toward Cost Containment

In response to increasing costs on all fronts, regulatory steps were taken in the early 1970's and onward in an attempt to reduce health care expenditures.⁹¹ Although there have been numerous enactments affecting health care at both the state and federal level over the last 25 years, three developments have had a significant impact on the reshaping of health care delivery and the ultimate injection of managed care cost containment mechanisms into the provider-patient relationship.

Of the three significant developments in health care delivery, two were enacted by Congress in the 1970's. First, in 1972 Congress enacted the Professional Standards Review Organizations (PSROs), later restructured as Peer Review Organizations.⁹² This program introduced into the Medicare

91. RANDALL, *supra* note 16, at 4, 20.

92. RANDALL, *supra* note 16, at 27-28. The purpose of the PSRO's as indicated by Congress was to assure, through the application of suitable procedures of professional standards review, that the services for which payment could be made would conform to appropriate professional standards for the provision of health care and that payment for such services would be made (i) only when, and to the extent medically necessary, as determined in the exercise of reasonable limits of professional discretion; and, (ii) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services could not, consistent with professionally recognized health care standards, effectively

system oversight in the form of quality and utilization review.⁹³ Next, Congress in 1973 passed the Health Maintenance Organization Act.⁹⁴ Finally, adding to Congressional efforts, the private sector actively promoted health care cost containment initiatives.⁹⁵

III. PEER REVIEW ORGANIZATIONS AND UTILIZATION MANAGEMENT

As a result of a rising concern that physicians and hospitals in the Medicare and Medicaid programs were over utilizing services, PSROs were implemented to look over the shoulders of physicians in order to determine whether the suggested course of treatment for the patient was adequate and medically necessary.⁹⁶ This system existed in one form or another well before the introduction of PSROs. Beginning with Medicare's introduction in 1965, hospitals receiving Medicare reimbursement were required to establish review panels for the purpose of monitoring quality and appropriateness of care.⁹⁷ Also, indemnity insurance plans had for the most part conducted retrospective review upon receipt of claims from providers for payment.⁹⁸

Those who supported PSRO's and their peer review process believed that an analysis of records and other information would detect those physicians who over utilized procedures, resulting in a decrease in health care costs over time.⁹⁹ However, as in the past, some in the medical field saw a threat to autonomy and third-party interference in the provider-patient relationship. In 1975 the implementation of PSROs was challenged in court by providers. However, a federal district court in Illinois denied the Association of American Physicians and Surgeons' (Association) claims challenging the legality of PSROs, using

be provided on an out-patient basis or more economically in an in-patient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion. RANDALL, *supra* note 16, at 27-28.

93. Other important factors leading to the shift toward managed care were (1) the move from retrospective cost reimbursement for hospitals to the prospective payment system (phased in beginning in 1983) and (2) physician reimbursement from customary, prevailing, and reasonable fees to fee schedules based on the resource based relative value scales (phased in beginning in 1992). These modifications in reimbursement resulted in a decrease in the amount of reimbursement received for Medicare related care. As a result, providers increasingly shifted costs to non-Medicare patients resulting in increased expenditures for private payers. See, MUELLER, *supra* note 62, at 86.

94. See 42 U.S.C. §§ 300e-300aaa (1991).

95. SALMON, *supra* note 31, at 55-77.

96. LEYERLE, *supra* note 1, at 52-53.

97. DAVIS, *supra* note 53, at 21 (noting that Blue Cross had well established utilization review programs).

98. Michael A. Dowell, *Avoiding HMO Liability for Utilization Review*, 23 U. TOL. L. REV. 117 (1991).

99. LEYERLE, *supra* note 1, at 52-53.

language that would seem to approve today's cost containment systems. Interestingly, the Association argued that PSROs were improper for the following reasons: (i) peer review violated a physician's right to practice medicine; (ii) interfered with the physician's obligation to independently exercise skill and judgment; and, (iii) interfered with the physician-patient relationship, and invaded the patients right to privacy.¹⁰⁰

In denying all of the Association's claims, the district court determined that PSRO standards did not prevent the physician from performing his or her duties and exercising professional skill and judgment. Rather, the standards merely indicated that if the physician wanted to be paid for services rendered, compliance with Medicare program standards and guidelines was necessary.¹⁰¹ Importantly, the court held that such compliance did not constitute economic coercion and was appropriate.¹⁰²

Their validity affirmed, PSROs were given the task of isolating cases where it appeared that services rendered were unnecessary or could have been performed more efficiently in an out-patient setting. This responsibility was later expanded to cover cases where the services provided were considered to be unacceptable medical practice.¹⁰³ Unfortunately, the original PSROs created by Congress were cumbersome and inefficient. As a result, in 1982 Congress repealed the original PSRO legislation, and in its place it created Peer Review Organizations (PROs).¹⁰⁴ The PROs differed from PSROs in that private groups were awarded contracts to perform peer review for government

100. See *Association of Am. Physicians & Surgeons v. Weinberger*, 395 F. Supp. 125, 130-31 (N.D. Ill. 1975), *aff'd mem. sub nom.*, *Association of Am. Physicians & Surgeons v. Matthews*, 423 U.S. 975 (1975).

101. *Id.* at 128-29. In examining the rising cost of the Medicare programs the Senate Committee on Finance stated:

The Committee on Finance has, for several years, focused its attention on methods of assuring proper utilization of these services. That utilization controls are particularly important was extensively revealed in hearings conducted by the subcommittee on medicare and medicaid. Witnesses testified that a significant proportion of the health services provided under medicare and medicaid are probably not medically necessary. In view of the per diem costs of hospital and nursing facility care, and the costs of medical and surgical procedures, the economic impact of this overutilization becomes extremely significant. Aside from the economic impact, the committee is most concerned about the effect of overutilization on the health of the aged and the poor. Unnecessary hospitalization and unnecessary surgery are not consistent with proper health care.

Id. (quoting Sen. R. No. 92-1230, 92d Cong. § 254 (1972)).

102. *Id.* at 134.

103. LEYERLE, *supra* note 1, at 52-53.

104. LEYERLE, *supra* note 1, at 54. The PROs originally covered fifty-four areas, a substantial reduction from the one hundred and ninety five areas covered by the PSROs. Today there are forty-two PRO's which cover fifty-three PRO areas. See, FURROW, *supra* note 50, at 86-87.

sponsored health programs.¹⁰⁵ PROs, while performing functions similar to those of the PSROs, were given many other responsibilities, such as ferreting out improper care for appropriate sanction.¹⁰⁶ In part, the PROs suffered from the same deficiencies that the PSROs exhibited: costs incurred in attempting to reduce utilization at times exceeded any potential savings. Part of the problem from an administrative cost standpoint, which payers in the health care system constantly battled, was the PROs attempts to transfer their costs to the provider. For example, PROs, as part of their review function, directed providers to copy and transport (at the providers' expense) patient records to PRO offices for review.¹⁰⁷ These and other government regulations resulted in significant costs for providers. These additional costs, like many others, were shifted to private payers resulting in an adverse impact on employers who provided significant health care benefits to employees.¹⁰⁸

Even with such deficiencies, the potential benefits from PSROs were not lost on the private sector. In a span of eight years, 25 percent of PSROs had entered into contracts with private entities to provided utilization review services.¹⁰⁹ Positive results from private sector utilization review programs fueled their growth. For example, by the late 1970's John Deere & Company reported that its utilization review program resulted in a 30% decrease in employee hospital days. General Motors reported a reduction in costs of over \$2 billion.¹¹⁰ Between 1982 through 1985, 27% of companies had injected utilization review into their employee health plans. By 1989, one survey indicated that approximately 125 utilization review companies provided services to organizations with as few as ten thousand individuals to as many as eleven million.¹¹¹ Today, approximately nine out of ten employers have some form of peer and utilization review mechanisms in their health plans.¹¹²

Over the last 25 years, the peer review and utilization monitoring has evolved into the industry of utilization management (UM or "utilization review"), a critical link in the cost containment process.¹¹³ Today UM is

105. LEYERLE, *supra* note 1, at 54.

106. LEYERLE, *supra* note 1, at 72.

107. LEYERLE, *supra* note 1, at 90-91.

108. LEYERLE, *supra* note 1, at 89-90. The PROs attempts to shift these costs to providers was ultimately found to be in violation of the Administrative Procedure Act. *See Burlington Memorial Hosp. v. Bowen*, 644 F. Supp. 1020 (W.D. Wis. 1986).

109. LEYERLE, *supra* note 1, at 70-71.

110. BRADFORD H. GRAY, *THE PROFIT MOTIVE AND PATIENT CARE* 299-300 (1991).

111. *Id.* at 261.

112. CHARLES G. BENDA & FAY A. ROZOVSKY, *MANAGED CARE AND THE LAW* § 1.4 (1996).

113. Mary R. Kohler, *When the Whole Exceeds the Sum of its Parts: Why Existing Utilization Management Practices Don't Measure Up*, 53 U. PITT. L. REV. 1061, 1062-63 (1992).

conducted by insurance companies, third party administrators, managed care entities, and private companies that provide specialized UM services.¹¹⁴ UM in these areas involves a myriad of functions. Techniques include monitoring the practice patterns of providers,¹¹⁵ case management of high cost cases,¹¹⁶ referral management,¹¹⁷ and service and coverage authorization.¹¹⁸ The monitoring of provider practice patterns includes the use of medical management guidelines to educate providers on quality and efficiency.¹¹⁹ Information obtained from historical practice patterns are compared with those of other providers.¹²⁰ This process, known as profiling, is used in part to isolate inefficient and low quality providers.¹²¹ Case management of high cost cases includes high intensity and low intensity programs.¹²² In high intensity programs, a great amount of the case manager's time is spent with the subscriber designing a plan which sets forth the services the subscriber will receive.¹²³ On the other hand, low intensity programs focus on inpatient use and authorization.¹²⁴ Referral management requires a plan subscriber to obtain the authorization of a primary care physician (gatekeeper) before seeing a specialist or scheduling for non-routine examinations or procedures.¹²⁵ Finally, in the service and coverage authorization mode, UM compares services provided to a patient with established criteria developed from information obtained from comparable patients in order to determine if proposed, ongoing, or completed health care services are medically necessary.¹²⁶

Prospective UM occurs when a decision is rendered regarding the necessity of proposed care.¹²⁷ This process may include pre-admission review for emergency room care, hospitalization, second opinions for surgeries, and review by the subscriber's primary care physician. When a patient is receiving treatment, concurrent UM may occur in order to determine if the plan of treatment is appropriate, and if not appropriate, advise the provider and patient

114. GRAY, *supra* note 110, at 275.

115. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *supra* note 90, at 81.

116. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *supra* note 90, at 81.

117. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *supra* note 90, at 80.

118. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *supra* note 90, at 80.

119. See Michael Daly, *Attacking Defensive Medicine Through the Utilization of Practice Parameters*, 16 J. LEGAL MED. 101, 106-08 (1995).

120. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *supra* note 90, at 81.

121. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *supra* note 90, at 81.

122. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *supra* note 90, at 81.

123. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *supra* note 90, at 81.

124. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *supra* note 90, at 80-81.

125. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *supra* note 90, at 80-81.

126. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *supra* note 90, at 80-81.

127. Cheralyn E. Schessler, *Liability Implications of Utilization Review as a Cost Containment Mechanism*, 8 J. CONTEMP. HEALTH L. & POL'Y 379, 383 (1992).

that payment for the care will not be authorized.¹²⁸ Finally, the more traditional, and probably least effective UM method from a cost savings standpoint, is retrospective review, a process that occurs after the services have already been performed.¹²⁹ UM services can be performed by payers, providers, or by UM entities that directly contract with the payer or provider.¹³⁰ The UM process that has generated the most interest occurs at the prospective level. The goal of pre-authorization programs is to avoid expenditures on unnecessary care and provide cost efficient alternatives such as out-patient services.

Logistically, the UM process entails a review of the subscriber's case, usually by a registered nurse, who analyzes the care or procedures proposed or provided in order to determine whether they fall within the managed care entity's utilization standards. After this initial analysis has been completed and it has been determined that the treatment is not within the standards, the case is presented to a UM physician or medical director for further analysis. If, after consultation with the subscriber's physician, it is determined that the care is not medically necessary, payment will not be authorized.¹³¹ In the event it is determined that the requested service is not medically necessary and thus not covered under the policy, the subscriber can elect to pay for the service out of pocket or pursue an appeal of the decision.¹³²

The standards relied upon by the reviewing nurse or physician in making a determination have in many instances been developed from previous studies conducted by managed care organizations, medical associations, government agencies, and insurance and UM companies. Sources relied upon in UM include the Appropriateness Evaluation Protocol, Intensity of Service, Severity of Illness, Discharge and Appropriateness Screening Criteria, and the Standardized Medreview Instrument. These standards evolved from programs funded by the government to develop criteria for the PSRO's. In addition, databases have been developed commercially for use in the UM process. Such systems include programs developed by the Health Data Institute, Medi Qual Systems, Inc. and SysteMetrics.¹³³

The standards utilized in making UM decisions include, but are not limited to, the following: itemized listing of procedures that will not be approved due to a lack of medical necessity or are simply not covered by the health plan; whether the procedure is more appropriate in an out-patient setting;

128. RANDALL, *supra* note 16, at 27-29.

129. See DOWELL, *supra* note 98, at 117.

130. RANDALL, *supra* note 16, at 28.

131. DOWELL, *supra* note 98, at 118.

132. GRAY, *supra* note 110, at 288.

133. GRAY, *supra* note 110, at 291-93.

specific criteria which justify exceptions to established standards due to a subscriber's medical history or other factors; standards which require a second opinion or which indicate that a second opinion is not necessary; factors which address issues relating to hospital admission or reduction in additional days requested by provider; and, standards for evaluating proposed medical procedures.¹³⁴

Although the specific standards employed by UM organizations may differ, the standards that have been developed (and are continually revised) are the result of significant study and agreement among professionals and organizations in the health care field.¹³⁵ These standards are also beginning to be utilized as a yardstick to measure efficient practitioners and create consistency in patient care.¹³⁶

Today, those employed in UM are active in organizations that have been involved in the development of suggested standards and criteria to be implemented in day-to-day UM activities. One of the main organizations involved in development of accreditation standards for UM organizations is the Utilization Review Accreditation Commission (URAC).¹³⁷ URAC, along with groups such as the American Medical Peer Review Association, Health Insurance Association of America, and Blue Cross and Blue Shield Association have developed standards and criteria which include the following: (i) UM standards and criteria based upon information provided by medical professionals; (ii) provider and payer awareness of UM standards and criteria; (iii) UM decisions provided within 48 hours; (iv) no delay in admission for emergency cases; (v) appropriately trained reviewers and physicians who are utilized when procedure approval is denied; (vi) taking actions to contact the attending physician prior to procedure denial; (vii) providing written notice of procedure denial to the subscriber, physician and care facility within 48 hours, after initial verbal contact; (viii) patient confidentiality protection; and, (ix) appropriate review process for adverse decisions.¹³⁸

In addition to the guidelines above, many states have enacted laws regulating individuals and entities providing utilization management services. The state of Florida for example requires an appropriate registration application

134. GRAY, *supra* note 110, at 290.

135. See GRAY, *supra* note 110, at 296-97.

136. For an excellent in depth discussion, see NATIONAL HEALTH LAWYERS ASSOCIATION, THE COLLOQUIUM REPORT ON LEGAL ISSUES RELATED TO CLINICAL PRACTICE GUIDELINES (1995).

137. See *Outside Accreditation of Managed Care Plans*, THE MANAGED CARE HANDBOOK 237-40 (2d ed. 1993).

138. DOWELL, *supra* note 98, at 126 (Guidelines for Health Benefits Administration Concurrent Review and General Administrative Procedures (1990)).

which details policies and procedures, the names of qualified personnel and the appeal process.¹³⁹

IV. HEALTH MAINTENANCE ORGANIZATION ACT OF 1973 AND RISK SHIFTING THROUGH INCENTIVE ARRANGEMENTS WITH HEALTH CARE PROVIDERS

Private enterprise recognized early that utilization review in the format developed by the government, although having potential benefits, could only be successful if implemented in conjunction with the other cost containment mechanisms such as increased patient cost sharing, employee wellness programs, and delivery systems such as health maintenance organizations.¹⁴⁰

Thus, one of the other links in the cost containment chain, financial risk shifting, has slowly evolved as a result of Congress's actions in breathing new life into the "health maintenance strategy" with the enactment of the Health Maintenance Organization Act in 1973 (the HMO Act).¹⁴¹ The term "Health Maintenance Organization" (HMO) was first used by Dr. Paul M. Ellwood in the early 1970's in an effort to garner support for health care delivery systems which were efficient and not based upon the long existing fee-for-service system.¹⁴²

The uniqueness of HMOs was that they not only financed health care, but participated in the delivery of health care to their subscribers as well. The early HMOs delivered health care services through an employed physician staff, similar to the system implemented by the GHA in the late 1930's discussed above. HMO subscribers received a pre-determined set of benefits from staff physicians.¹⁴³

Interestingly, the HMO Act came about as a result of significant corporate support in response to rising health care costs for employee health care

139. See FLA. STAT. ch. 395.002(29) (1995) defining utilization review as "a system for reviewing the medical necessity or appropriateness in the allocation of health care resources of hospital services given or proposed to be given to a patient or group of patients." *Id.*

140. See DAVIS, *supra* note 53, at 125. The UM industry has even recognized that UM alone cannot solve the problem of rising health care costs. The Institute of Medicine's Committee on Utilization Management has indicated that, although UM has helped reduce inpatient hospital stays, it has not changed increases in overall health care costs. See GRAY, *supra* note 110, at 302.

141. Health Maintenance Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (1973). In 1972, the National Association of Insurance Commissioners drafted model legislation for state sponsored HMOs. Since 1972, many states have enacted HMO legislation.

142. Salmon, *supra* note 31, at 85; see also Paul Ellwood, *Health Maintenance Organizations: Concept and Strategy*, HOSPITALS, March 16, 1971, at 53.

143. McGraw, *supra* note 71, at 1823.

benefits.¹⁴⁴ Corporate concern however did not come about overnight. During the preceding decade the "class conscious corporate directorate" became increasingly involved with health care issues,¹⁴⁵ as the influence of long-standing health care interests diminished.¹⁴⁶ As 1970 arrived, corporate support of the HMO Act was bolstered by Ellwood, who emphasized the potential savings that could result from using HMOs.¹⁴⁷

The original HMO legislation provided for federal grants to establish private HMOs and included criteria for the types of benefits which were to be provided to enrollees.¹⁴⁸ The Act also set forth the requisite standards for federally qualified HMOs and preempted state laws, which as previously mentioned, made it difficult to implement ACCS's. From 1973 to 1983 over \$350 million in grants and loans were provided by the government to establish HMOs around the country.¹⁴⁹ Although funding stopped in 1981, the government has continued to follow a policy of promoting the development of HMOs by fostering private competition and authorizing Medicare and Medicaid enrollment.¹⁵⁰ Since the early 1970's, subscribership in HMOs has gone from roughly 3.6 million¹⁵¹ to a projected 65 million in 1996.¹⁵² The following diagram (in millions) shows just how rapidly America is moving toward managed care arrangements and away from traditional health care delivery.¹⁵³

144. Salmon, *supra* note 31, at 86-87.

145. Salmon, *supra* note 31, at 85.

146. Salmon, *supra* note 31, at 85 (including the American Medical Association, American Hospital Association, American Public Health Association, and the Association of American Medical Colleges).

147. Salmon, *supra* note 31, at 87. A recent editorial by Dr. Ellwood addressing the state of the American Health System and steps which will be taken in the next phase of the managed care phenomenon can be found at Paul Ellwood, *Managed Care: A Work In Progress*, 276 JAMA 13, Oct. 2, 1996, at 1083-86.

148. DAVIS ET AL., *supra* note 53, at 134-35.

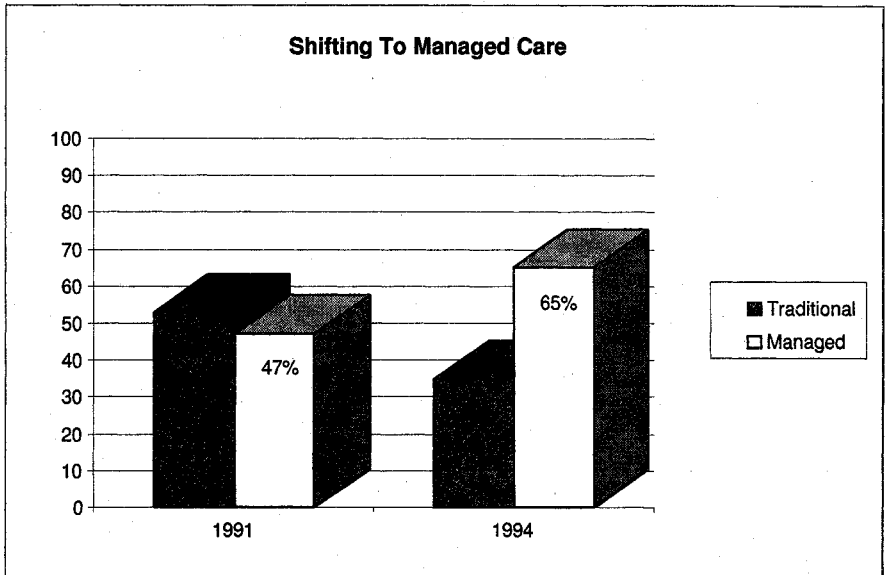
149. DAVIS ET AL., *supra* note 53, at 135.

150. DAVIS ET AL., *supra* note 53, at 135. During the first part of 1994, 5.1% of Medicare beneficiaries and 17.2% of Medicaid beneficiaries were enrolled in managed care plans. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, *supra* note 90, at 136. These numbers have continued to increase. It is now estimated that nearly 4 million Medicaid recipients are enrolled in managed care plans. HMO, *supra* note 31, at 62.

151. McGraw, *supra* note 71, at 1823.

152. Julie Johnson, *HMOs Dominate, Shape the Market*, 39 AMERICAN MEDICAL NEWS, Jan. 22-29, 1996, at 1, 7.

153. RUTH FINKELSTEIN ET AL., THE MANAGED CARE CONSUMERS BILL OF RIGHTS 6 (1995).



The risk shifting mechanisms utilized by HMOs and other managed care organizations, were eloquently described by Judge Posner recently in the *Marshfield Clinic* case when he wrote the following:

The risk shifting feature of the concept lies in the fact that if the subscriber incurs above-average medical expenses, the excess cost is borne by the HMO rather than by the subscriber (or by his insurer, or more likely by both because of co-payment and deductible provisions in the insurance policy), while if he incurs below-average medical expense the difference enures to the benefit of the HMO rather than to him or his insurer (or, again, both). To control the upside risk that it incurs, the HMO provides medical services through physicians with whom it has contracts specifying their compensation, rather than merely reimbursing some percentage of whatever fee they might happen to charge for their services.¹⁵⁴

Risk shifting mechanisms in the form of financial incentive arrangements with health care providers utilized by HMO's and other managed care vehicles come in various shapes and sizes. However, the most recognized financial arrangements include managed fee-for-service, capitation, and financial incentive arrangements.¹⁵⁵ Under the managed fee-for-service arrangement,

154. *Blue Cross & Blue Shield United v. Marshfield Clinic & Sec. Health Plan, Inc.*, 65 F.3d 1406, 1409 (7th Cir. 1995).

155. HOWARD S. ROWLAND & BEATRICE L. ROWLAND, *HOSPITAL LEGAL FORMS CHECKLISTS, & GUIDELINES* 39:29-39:32 (1986).

discounts are applied to the usual and customary charges or discounted fee schedules are utilized.¹⁵⁶ Capitation arrangements usually reimburse the provider with a specific payment for each subscriber on a monthly basis.¹⁵⁷ This payment method acts to shift a portion of risk to the provider. Under a capitation arrangement, the provider incurs a service risk as well as a potential financial risk. In terms of the service risk, the physician is obligated to provide his time to the patient, whether it be one visit or numerous visits to the provider's office. With respect to financial risk, the provider faces exposure if he or she has a panel of patients that require higher levels of care.¹⁵⁸ Under the managed fee-for-service or capitation arrangement, a percentage of the total amounts which are to be paid to the providers are withheld for later distribution, if certain performance goals are met.¹⁵⁹ Finally, risk based financial incentive arrangements include designated funds which are set aside for disbursement at the conclusion of the year. These designated funds or "risk pools" are allocated based upon whether certain goals or projections have been met by the provider or group. Performance goals are established for separate risk pools that can encompass hospital referrals, emergency room referrals, consultative (specialist) services, and quality assurance pools.¹⁶⁰ In a recent survey, risk sharing with providers was prevalent in HMO's, but not in PPO's, which primarily used a fee-for-service payment arrangement. Interestingly, of the 108 managed care organizations responding to the survey, fifty percent of the staff or group model HMO's and seventy-four percent of the network or independent practice association model HMO's calculated payments to providers based upon utilization and cost patterns.¹⁶¹ The following diagram shows the various types of financial arrangements between physicians and managed care entities:¹⁶²

156. *Id.* at 39:29. Other managed fee-for-service arrangements include the following: (i) global fees which are in the nature of a single payment for a designated procedure; (ii) global fees with specific outcomes which pay a single fee for a designated procedure including additional care relating to the initial procedure; and (iii) target expenditures which include a sum of money designated for provider service. *Id.*

157. *Id.* at 39:30. For an excellent discussion of the various models of capitation, see Thomas S. Bodenheimer, M.D., M.P.H. *et al.*, *Capitation or Decapitation: Keeping Your Head in Changing Times*, 276 JAMA 13, Oct. 2, 1996, at 1025-31.

158. ROWLAND & ROWLAND, *supra* note 155, at 39:30.

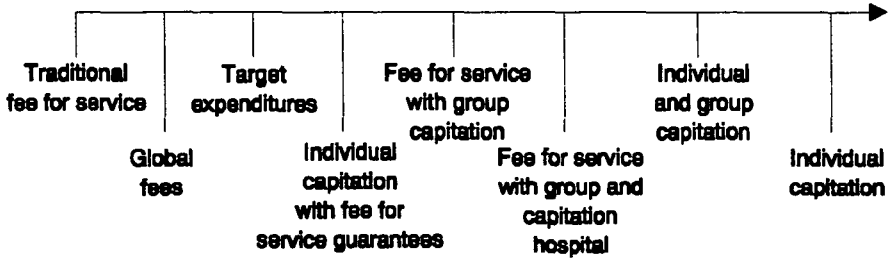
159. ROWLAND & ROWLAND, *supra* note 155, at 39:32.

160. ROWLAND & ROWLAND, *supra* note 155, at 39:31.

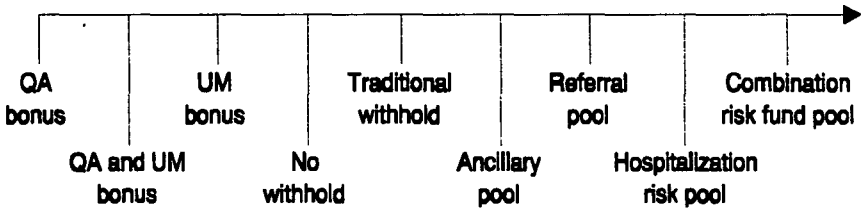
161. Marsha R. Gold *et al.*, *A National Survey of the Arrangements Managed Care Plans Make with Physicians*, 333 N. ENG. J. MED. 1678, 1680-81 (1995).

162. ROWLAND & ROWLAND, *supra* note 155, at 39:29, 37:5. Hospital and HMO payment arrangements can include fee-for-service, withhold arrangements, capitation, per-diem and DRG-related payments.

Physician Compensation



Risk Based Payments



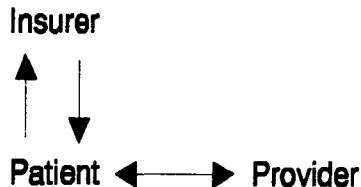
The government's pro-competitive policy, private sector efforts, and innovations in the implementation of ACCS's have started to bear fruit. These systems bring together the two critical elements for cost efficient health care: finance and delivery. By combining these two elements, a bridge has been built across the gulf that once existed between the provider and payer. As a result, the provider must not only provide care but must also act as a cost efficient manager with respect to the care provided. Taking on this new responsibility, the provider becomes a player, rather than spectator, in this nation's effort to control health care costs. Recent reports have indicated that spiraling costs have begun to level off and employer paid premiums for health care have in many instances decreased.¹⁶³

163. INTERNAL MEDICINE NEWS, vol. 29, no. 4, Feb. 15, 1996, at 1 (citing KPMG Peat Marwick national survey of 1,037 employers with at least 200 or more employees). In 1995 HMO premiums increased just 0.4% compared with a 9.8% increase in 1992. PPOs and POSs have experienced similar slowdowns in premium increases. On the whole, 1995 saw a 2.1% increase compared with a 10.9% increase in 1992. *Id.*

V. MANAGED CARE MODELS: HMOs, PPOs, PHOs AND IDSS

As indicated above, HMO's are unique in that they not only finance health care but also participate in its delivery. Although the differing managed care models will be discussed in detail below, these vehicles share some of the same operational characteristics, including the following: (i) subscribers (employer or individual) submit fixed premiums to the HMO or managed care organization ("MCO"); (ii) subscribers receive a pre-determined menu of benefits from only authorized providers identified by the HMO; (iii) other than in instances where a small co-payment is required, subscribers are not normally billed for services provided by HMO authorized providers; (iv) utilization management, subscriber relations, marketing and other operational functions are the responsibility of the HMO entity; and, (v) the HMO is responsible for appropriate selection of providers, regardless of the applicable model.¹⁶⁴ The following diagram shows the distinctions between the traditional fee-for-service system and managed care models:¹⁶⁵

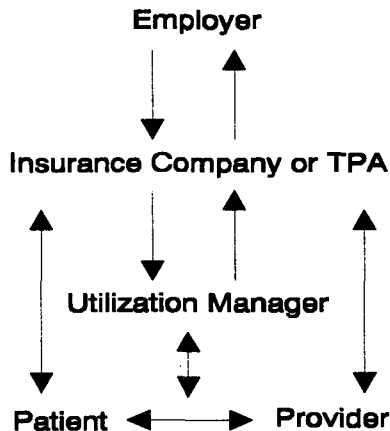
Traditional Health Care



164. James P. Freiburg, *The ABCs of MCOs: An Overview of Managed Care Organizations*, 81 ILL. B.J. 584, 585-86 (1993).

165. BENDA & ROZOVSKY, *supra* note 112, at 2-6.

Managed Health Care



Because HMOs participate in the financing of health care delivery, they are subject to government regulation. The HMO Act of 1973 and subsequent amendments regulate federally qualified HMO's, while at the same time many states¹⁶⁶ have enacted similar laws and regulations.¹⁶⁷

There are several well recognized HMO models. These include the staff model, group/network model and independent practice association ("IPA") model. In addition, models such as the preferred provider organization and physician-hospital organization unlike HMOs, are not involved in the financing of delivery but rather contract with payers to provide health care services at discounted rates.

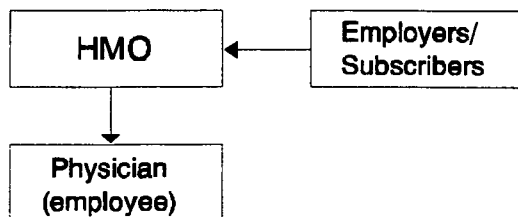
A. Staff Model

In the staff model, providers are full-time salaried employees who provide services exclusively to subscribers of the HMO. In addition, clinical, laboratory, and imaging facilities, where subscribers receive health care

166. BARRY R. FURROW ET AL., HEALTH LAW 309 (1995). Generally, the states which have HMO legislation regulate both delivery and insurance issues.

167. FLA. STAT. ch. 641 (1995), referred to as the "Health Maintenance Organization Act," addresses a wide array of areas, including certification requirements, surplus requirements, member and provider contract language requirements, and annual reporting requirements. *Id.*

services are usually owned by the HMO.¹⁶⁸ The staff model is depicted in the following diagram:¹⁶⁹



B. Group and Network Model

In the group model, the providers rather than being employees of the HMO are associated with a physician group practice. Depending on the circumstances, the group may have been established well before entering into an arrangement with the HMO or may have been created in order to compete for HMO provider agreements.¹⁷⁰ In most instances, the HMO will pay the group practice on a capitated basis. When payment is capitated, the HMO reimburses the group practice on an agreed upon fixed payment per-patient, despite the nature or intensity of service provided.¹⁷¹ The group practice will usually have various methods for reimbursing its providers including fixed salary, reduced fee-for-service, or capitation.¹⁷² The group model is depicted in the following diagram:¹⁷³

168. HOW TO FIND THE BEST DOCTORS, HOSPITALS AND HMOs 177 (1995).

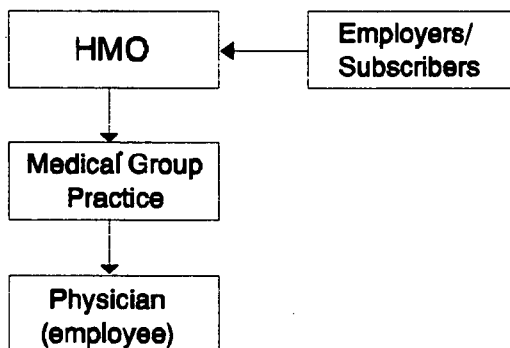
169. THOMAS C. FOX ET AL., *Health Care Financial Transactions Manual*, ch. 11, at 11-6 (1995).

170. BENDA & ROZOVSKY, *supra* note 112, at 2-11. The group may have been created by the HMO in order to provide health care services to the HMO's subscribers. BENDA & ROZOVSKY, *supra* note 112, at 2-11.

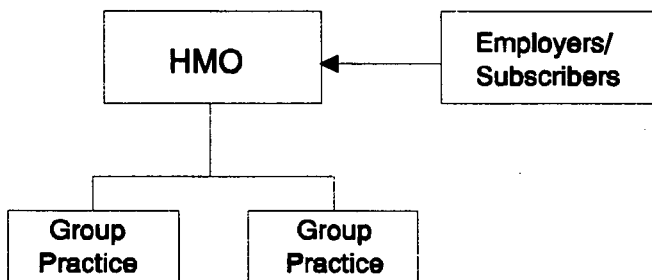
171. R. FINKELSTEIN ET AL., *supra* note 153, at 79.

172. BENDA & ROZOVSKY, *supra* note 112, at 2-11.

173. FOX ET AL., *supra* note 169, at 11-6.



A hybrid of the group model is the network model. In this model, the HMO contracts with numerous groups in order to provide its subscribers with services which they require. An HMO would turn to the network model in situations where groups providing specialization services are not available in the subscriber area.¹⁷⁴ The network model is depicted in the following diagram:¹⁷⁵



It should be noted that under any of the above arrangements, the HMO can offer to its subscribers a point-of-service option. If such an option is provided, subscribers are not required to first see their primary care physician

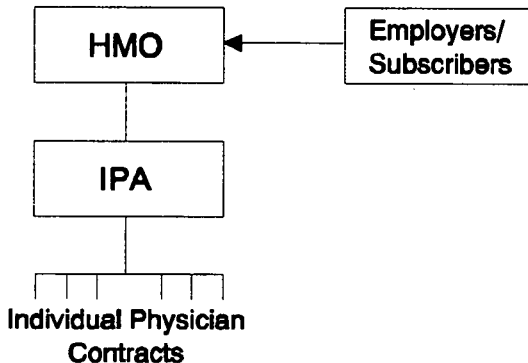
174. BENDA & ROZOVSKY, *supra* note 112, at 2-11 to 2-12. Group and staff model HMOs have closed panels in that the physicians are permitted to provide service exclusively to subscribers, but only if the provider is employed by the HMO or associated with the group that has an agreement with the HMO. A network model on the other hand can be an open or closed panel. BENDA & ROZOVSKY, *supra* note 112, at 2-12.

175. FOX ET AL., *supra* note 169, at 11-6.

but instead may opt to go "out of network" in return for paying a higher deductible or co-payment.¹⁷⁶

C. Independent Practice Association Model

Under the IPA model, individual providers contract with a separate entity called an IPA, an organization that then enters into agreements with various HMOs and other third party payers. The providers continue to practice out of their offices and are paid by the IPA on a capitated or discounted fee-for-service basis.¹⁷⁷ IPAs originated in the 1970's to provide individual practitioners a vehicle within which to compete with pre-paid group practice plans.¹⁷⁸ The IPA model is depicted in the following diagram:¹⁷⁹



D. Preferred Provider and Physician-Hospital Organization Models

Under the PPO model, providers contract with the PPO and agree to provide health care services at reduced fee-for-service rates. Subscribers under contract with the PPO receive discounted rates when utilizing providers in the network. A critical component for obtaining reduced costs under the PPO

176. BENDA & ROZOVSKY, *supra* note 112, at 2-14. Point-of-service options are also available under the preferred provider model. BENDA & ROZOVSKY, *supra* note 112, at 2-14.

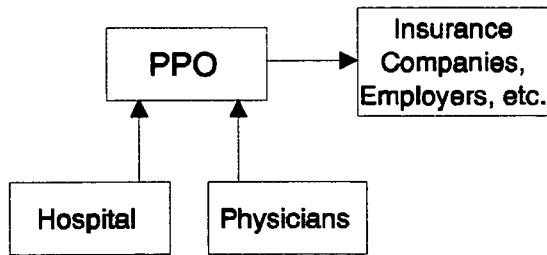
177. BENDA & ROZOVSKY, *supra* note 112, at 2-12. An IPA model normally operates on an open panel basis, allowing the provider to provide services to individuals who are not subscribers of the HMO. BENDA & ROZOVSKY, *supra* note 112, at 2-12.

178. GRAY, *supra* note 110, at 217.

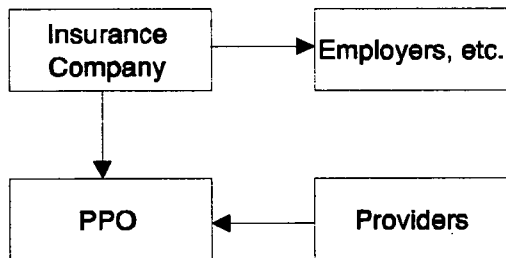
179. FOX ET AL., *supra* note 169, at 11-6.1.

model is the proper selection of efficient providers.¹⁸⁰ The various PPO models are depicted in the following diagrams:¹⁸¹

Provider-Sponsored PPO

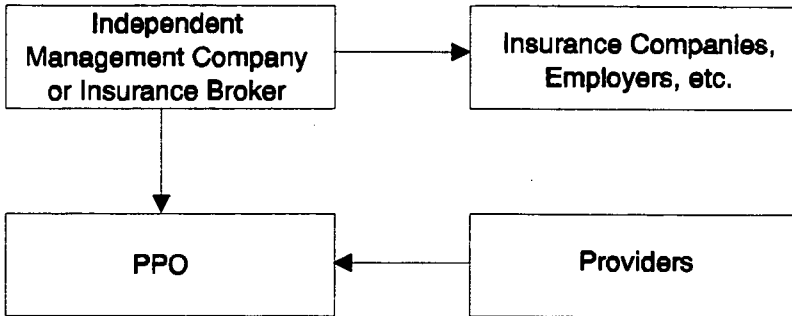
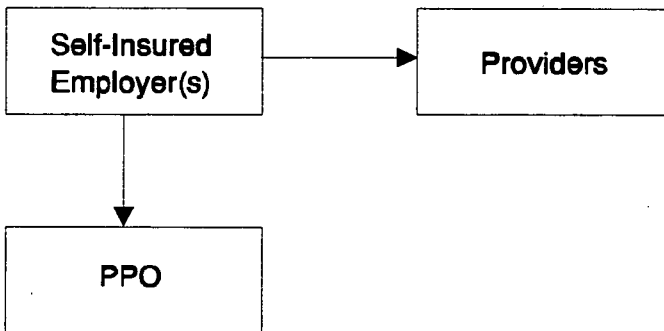


Insurance-Sponsored PPO



180. GRAY, *supra* note 110, at 217-18.

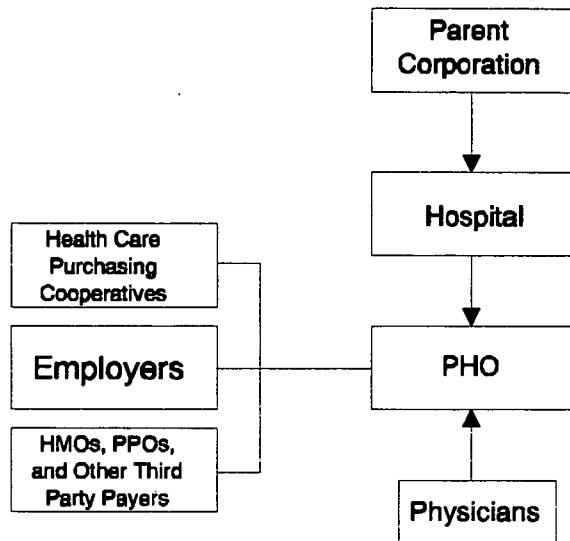
181. FOX ET AL., *supra* note 169, at 11-8, 11-9, 11-10.

Broker-Sponsored PPO**Employer-Sponsored PPO**

The PHO is a relatively new managed health care vehicle. A PHO is an arrangement between a group of physicians and a hospital, the purpose of which is to attract payer contracts from health insurers, employers, and HMOs. The PHO is structured as a for-profit corporation and operates in a fashion similar to a PPO or IPA.¹⁸² The PHO model is depicted in the following diagram.¹⁸³

182. BENDA & ROZOVSKY, *supra* note 112, at 2-14.

183. INTEGRATED HEALTH CARE DELIVERY SYSTEMS MANUAL, § 410, at 11 (1995).



Although other managed care models similar to the ones described above may use different acronyms, cost containment principles shared among them are similar. These principles include the following: (i) providers employed by or under arrangements with a managed care organization provide medical services at reduced rates to the managed care organization subscribers who, depending on the plan, pay higher deductibles or co-payments when going out of network; (ii) cost containment mechanisms such as utilization management and profiling are implemented; and, (iii) risk shifting arrangements between the managed care organization and its providers insure cost efficient care.¹⁸⁴

E. Integrated Delivery Systems

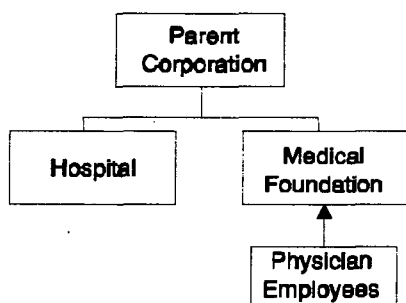
The managed care models outlined above are in many instances incorporated into cost containment strategies which include integrated delivery systems ("IDS"). Although, IDSs continue to evolve, these systems essentially attempt to bring together hospital and physician functions that have traditionally remained separate on administrative and structural levels. IDSs represent the effort by hospitals and physicians to combine resources for efficiency and to compete with other managed care entities.

184. Freiburg, *supra* note 164, at 585.

The foundation, hospital-controlled, joint-venture and medical-service organization represent the most recognized IDS models in the health care industry.

1. *Foundation Model*

In part, the foundation model has been developed in order to avoid potential problems created by the corporate practice of medicine doctrine.¹⁸⁵ Under the foundation model, a hospital creates a foundation which can be a for-profit or not-for-profit corporation. The foundation thereafter acquires the stock or assets of a physician practice. The physicians are employed by the hospital or enter into employment agreements with the foundation. In jurisdictions which continue to adhere to the corporate practice of medicine doctrine, the stock of the professional corporation will usually be controlled by a physician who is an administrative employee of the hospital. Pursuant to this arrangement, this physician is contractually obligated to transfer the stock of the professional corporation upon the occurrence of certain events spelled out in a stock transfer restriction agreement. An example of the foundation model is depicted in the following diagram:¹⁸⁶

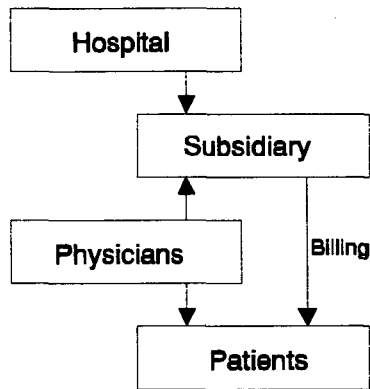


185. FOX ET AL., *supra* note 169, at 11-26. The corporate practice of medicine doctrine is discussed in depth in *Berlin v. Sarah Bush Lincoln Health Ctr.*, 664 N.E.2d 337 (Ill. App. Ct. 4th 1996). It should be noted that only a few states vigorously continue to enforce the corporate practice of medicine doctrine (ex. California and Texas). In Florida, the Board of Medicine has held that there is no prohibition on the practice of medicine by physicians as corporate employees. See *In re: Petition for Declaratory Statements of Conrad Goulet, M.D.*, 15 FLAR 4184 (1989); *Petition for Declaratory Statements of John W. Lister, M.D.*, 9 FLAR 6299 (1977).

186. FOX ET AL., *supra* note 169, at 11-26.

2. *Hospital-Controlled Model*

In the hospital-controlled model, a hospital will employ providers directly to provide health care services. Alternatively, the hospital may create a separate entity for purposes of operating an out-patient clinic. The clinic then employs providers or, alternatively, enters into other arrangements with providers for services to clinic patients. An example of the hospital-controlled model is depicted in the following diagram:¹⁸⁷

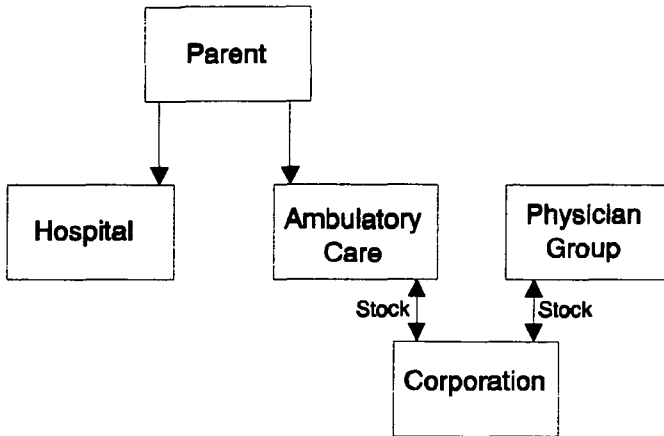


3. *Joint Venture Model*

In the joint venture model, a corporation, general partnership, limited partnership, or limited liability company is formed between a hospital and a number of physicians in order to create a business arrangement which can include anything from an HMO to an out-patient surgery center. These arrangements can be very complicated and often implicate a wide array of legal

187. FOX ET AL., *supra* note 169, at 11-27.

issues that can include tax, securities, anti-trust, referral, and anti-kickback statutes. An example of the joint-venture corporate model is depicted in the following diagram:¹⁸⁸

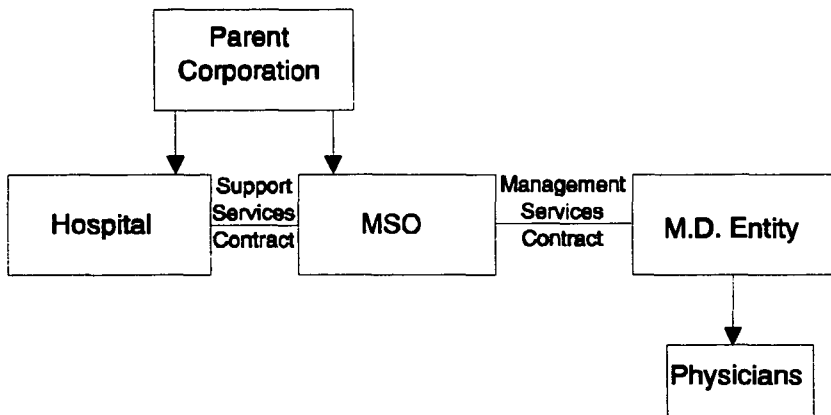


4. *Management and Medical Services Organization*

A management services organization (“MSO”) is a legally distinct entity created by a hospital or a joint venture between a hospital and a group of physicians. An MSO provides administrative services such as purchasing to physicians, physician groups, and hospitals. An entity that provides services

188. ROWLAND & ROWLAND ET AL., *supra* note 155, at 35:11.

exclusively to physicians and physician groups is known as a medical services organization. An example of a joint venture management services organization is depicted in the following diagram:¹⁸⁹



Many of the systems described above have implemented numerous cost containment measures, including UM and financial incentive arrangements between health care providers and payers. In one survey, 95 percent of the 108 managed care organizations responding implemented some form of UM, while 69 percent offered some form of risk sharing or financial incentives to their providers.¹⁹⁰ The potential liability issues arising from these two types of cost containment mechanisms will be discussed in the next section.

VI. EMERGING UTILIZATION MANAGEMENT LIABILITY CLAIMS

Managed care and competition, like other new systems or products introduced into the stream of commerce, are now beginning to face many rapids. These rapids, in the form of lawsuits, will test the staying power of UM and the widespread commitment to cost containment.

As mentioned at the beginning of this paper, some of these lawsuits have caught the eye of the media, resulting in articles which have been less than flattering about the managed care system. For instance, stories in prominent

189. INTEGRATED HEALTHCARE DELIVERY SYSTEMS MANUAL, *supra* note 183, § 410, at 6.

190. Gold et al., *supra* note 161, at 1681-82.

publications have questioned UM decisions that deny payment for proposed treatment and alternative financial arrangements between managed care companies and providers.¹⁹¹ One article even contained a list of things that HMO's allegedly failed to tell their subscribers.¹⁹² Two of the items on the list concerned UM and financial incentives. Specifically, with respect to UM, the article stated that an HMO's rule of thumb for its subscribers is that "you're not sick until we say you're sick," and on the issue of financial incentive arrangements between health care providers and payers, the article indicated that "the less your doctor sees you, the more he earns."¹⁹³ The irony of the present controversy is that under the so-called traditional system of health care, increased utilization (whether necessary or not) gave the provider financial incentive because it increased his or her income. In addition, without the benefit of practice protocols and UM, one could be treated any of ten different ways (efficiently or inefficiently) depending on the provider.

Although there have been instances where poor UM decisions have been made, the information to date does not warrant a complete indictment of the system as some propose. With respect to financial incentives, there is little evidence that subscribers have been adversely affected by such programs.¹⁹⁴ Importantly, the mere fact that a decision is made, or a program implemented is under the umbrella of managed care does not *ipso facto* make it improper or raise it to the level of negligent conduct.

Where imprudent decisions are purportedly made, careful analysis of the specific facts is necessary to determine the proper existence of liability. The application of general liability principles, and those which have emerged in the field of health law, must be considered whether one is dealing with an HMO, PPO, IPA, or one of the IDS models described above. These principles include individual provider liability for malpractice, liability in the context of the employment relationship under respondeat superior, claims arising from apparent or ostensible agency theories, corporate negligence,¹⁹⁵ breach of

191. Erik Larson, *The Soul of an HMO*, TIME, Jan. 22, 1996, at 44-52; Ellyn E. Spragins, *Beware Your HMO*, NEWSWEEK, Oct. 23, 1995, at 54-56. See also John E. Wave, Jr., Ph.D. et al., *Differences in Four-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-For-Service Systems*, 276 JAMA 13, Oct. 2, 1996, at 1039-47; Richard C. Reuben, *In Pursuit of Health*, 82 A.B.A. J., Oct. 1996, at 54-60; George Anders, *Who Pays Cost of Cut-Rate Heart Care?*, WALL ST. J., Oct. 15, 1996, at B1.

192. John Protos, *Ten Things Your HMO Won't Tell You*, SMARTMONEY, Mar. 1996, at 134-44. See also Susan Dentzer, *Inside the World of Managed Care*, U.S. NEWS & WORLD REPORT, April 15, 1996, at 56; Ronald Kotulak & Peter Gorner, *Medicine Aches with HMO Fever*, CHI. TRIB., Apr. 14, 1996, § 1, at 1, 16; Carol Jouzaitis, *States Crack Down on HMO's Abuse of Power*, CHI. TRIB., Apr. 15, 1996, § 1, at 1, 13.

193. Protos, *supra* note 192, at 134-44.

194. McGraw, *supra* note 71, at 1832.

195. See *Dunn v. Praiss*, 656 A.2d 413 (N.J. 1995). In *Dunn*, the New Jersey Supreme

contract, breach of warranty, and consumer based claims resulting from unfair and deceptive practices.¹⁹⁶ In addition, recent Employment Retirement Income and Security Act (ERISA) cases, which address the impact of preemption on a plaintiff's ability to pursue liability claims in the managed care arena, will be explored with respect to UM liability claims. Finally, the steps managed care entities must take in order to avoid potential liability claims relating to UM and financial incentive arrangements with health care providers will be considered.

A. The Genesis of UM Liability: *Wickline v. State of California* and *Wilson v. Blue Cross of Southern California*

The first legal attack against UM came in *Wickline v. California*.¹⁹⁷ The issue, as framed by the *Wickline* court, was whether a third party payer that had instituted a cost containment program was liable for injuries suffered by a subscriber as the result of cost containment decisions which adversely affected the implementation of the treating provider's medical judgment.¹⁹⁸ The relevant facts concerned Medi-Cal's decision to deny a treating physician's request for an eight-day extension of hospitalization for his patient. Medi-Cal administered California's Medicaid program.¹⁹⁹

The plaintiff-patient, Lois Wickline, had been treated for Leriche's Syndrome.²⁰⁰ The syndrome, which results in an obstruction of the terminal aorta, can only be treated through surgery.²⁰¹ The request for an extension resulted from complications that arose after the surgery. Making the request for the extension, Ms. Wickline's physician properly filled out and filed the form required by Medi-Cal.²⁰² The information contained on the form was ultimately reviewed by Medi-Cal's "on-site nurse" and later by a physician who acted as a Medi-Cal consultant.²⁰³ Ultimately, the consultant, Dr. Glassman, authorized only a four-day extension based on the information on

Court indicated that HMOs could be held liable under the doctrine of corporate negligence for acts arising from negligent selection and control of physicians, and for the corporation's independent acts of negligence such as management of utilization control systems. The court also indicated that the negligent physician could potentially assert a third party claim against an HMO. *Id.*

196. See Torin A. Dorros & T. Howard Stone, *Implications of Negligent Selection and Retention of Physicians in the Age of ERISA*, 21 AM. J. L. & MED. 383 (1995).

197. 228 Cal. Rptr. 661 (Cal. Ct. App. 1986).

198. *Id.* at 661.

199. *Id.* at 664-65.

200. *Id.* at 663.

201. *Id.*

202. *Id.* at 664.

203. *Id.* at 664-65.

the form.²⁰⁴ Dr. Glassman did not review any of Ms. Wickline's medical records or other information. As a result of Medi-Cal's decision denying the requested extension, Ms. Wickline's physician discharged her without making any appeal on her behalf.²⁰⁵ Shortly after discharge, Ms. Wickline began to suffer severe discomfort and consequently was readmitted nine days later.²⁰⁶

As a result of the complications which developed while she was at home, it became necessary to amputate her leg.²⁰⁷ Ms. Wickline filed suit against Medi-Cal for its consultant's negligence in discontinuing her stay in the hospital.²⁰⁸ Ms. Wickline prevailed at trial.²⁰⁹ On appeal, the verdict was reversed.²¹⁰ In its decision, the court acknowledged that the case appeared to be the first where a negligence claim had been asserted against a third-party payer for what was in essence a medical malpractice claim.²¹¹ In rejecting Ms. Wickline's argument, the court found that Medi-Cal had not overridden her treating physician's medical judgment.²¹² Rather, as a payer of medical care, Medi-Cal had implemented its responsibilities under a prospective utilization review program.²¹³ Acknowledging the significant impact such programs can have on cost savings as well as patient care, the court carefully reviewed the relevant law. Since Medi-Cal was not a party to the treating physician's decision to discharge Ms. Wickline, the court reasoned it could not be "held to share" in the harm which resulted.²¹⁴ The court indicated that, although it recognized that cost containment programs had become a part of the health care system, such systems should not corrupt the judgment of medical professionals.²¹⁵ The court further stated that third party payers of health care services can be held liable and legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms.²¹⁶ The only example provided by the court was based on issues in the case relating to the decision making process.²¹⁷

204. *Id.* at 665-66.

205. *Id.* at 666.

206. *Id.* at 667.

207. *Id.* at 668.

208. *Id.* at 662.

209. *Id.*

210. *Id.*

211. *Id.*

212. *Id.* at 670-71.

213. *Id.*

214. *Id.* The court acknowledged that the decision by Medi-Cal's consultant was in compliance with existing law in California regulating Medi-Cal, and that the principal treating physician did not utilize a reconsideration procedure within the Medi-Cal funding process to seek an extension of benefits for further hospitalization. *Id.*

215. *Id.* at 672.

216. *Id.* at 670-71.

217. *Id.* at 670-71. The court stated that liability may result where appeals made on a

The courts in California revisited the subject of UM liability in 1990. The decision in *Wilson v. Blue Cross of Southern California* broadly recognized UM liability.²¹⁸ Like *Wickline*, the *Wilson* case arose out of a UM decision which determined that no further payment would be forthcoming for any additional hospitalization. Unlike *Wickline*, in *Wilson* the health care coverage in question was a private, rather than publicly funded benefit plan.²¹⁹

The strange twist of facts which lead to the ultimate decision in *Wilson* began on March 1, 1983, when Howard Wilson, Jr., checked himself into the College Hospital in Los Angeles, California. He was complaining of depression, drug addiction, and anorexia.²²⁰ At the time, Mr. Wilson's health care benefits were covered under a policy issued by Alabama Blue Cross.²²¹ The facts established in the case indicated that California Blue Cross was obligated to provide the benefits in the insurance policy between Mr. Wilson and Alabama Blue Cross.²²² Approximately ten days after Mr. Wilson checked into the hospital, he was informed by his attending physician that the carrier would no longer pay for the hospitalization.²²³ The attending physician believed that Mr. Wilson needed three to four weeks of inpatient care.²²⁴ As a result of the carrier's decision, Mr. Wilson left the hospital; he committed suicide twenty days later.²²⁵

Mr. Wilson's estate asserted claims against Blue Cross of Southern California, Alabama Blue Cross, and Western Medical Review, which was the entity under contract to provide UM services to Blue Cross of Southern

patient's behalf for medical or hospital care are arbitrarily ignored, unreasonably disregarded, or overridden. *Id.*

218. *Wilson v. Blue Cross of Southern Cal.*, 271 Cal. Rptr. 876 (Cal. Ct. App. 2d 1990). The decision has been cited by commentators for the broad based recognition of UM liability. See David D. Griner, Note, *Paying the Piper: Third Party Payer Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861 (1991).

219. *Wilson*, 271 Cal. Rptr. at 880-81.

220. *Id.* at 877-78, 881-82.

221. *Id.* at 880-81.

222. *Id.* at 880. The relevant provisions of the contract stated as follows:

INPATIENT HOSPITAL SERVICE. While a member is covered under this Contract and is a registered bed patient in a Hospital, and during such time . . . as the Member's attending Physician determines that hospitalization is necessary, such Member shall be entitled to the following benefits, herein referred to as Hospital Service . . . Benefits for Mental and Nervous Disorders or for Pulmonary Tuberculosis . . . Benefits hereunder for mental and nervous disorders or for pulmonary tuberculosis shall be limited to an aggregate of thirty (30) days during any period of twelve (12) consecutive months.

Id.

223. *Id.* at 877-78.

224. *Id.* at 877, 881-82.

225. *Id.* at 878.

California.²²⁶ Mr. Wilson's estate also sued Dr. John Wasserman, who was an employee of Western Medical Review.²²⁷ It is critical to note that the claims asserted by the estate were based upon tortious breach of an insurance contract, inducing a breach of an insurance contract and wrongful death.²²⁸ The case was reviewed by the appellate court after the trial court had granted the defendants' motions for summary judgment.²²⁹ The lower court, granting the relief requested by the defendants, relied on *Wickline* and determined that the decision to discharge was the attending physician's responsibility and not the defendants'.²³⁰

Oddly enough, on review the court of appeals distanced itself from its prior decision in *Wickline*. In *Wickline*, the court held that the physician who complies without protest with the limitations imposed by a third-party payer cannot avoid ultimate responsibility for his patient's care when his medical judgment dictates otherwise.²³¹ On review, the *Wilson* court acknowledged that *Wickline* did not correctly state the law; rather, the *Wickline* court stated mere dicta, and not the law with respect to the issue of causation in a tort case.²³² The *Wilson* court indicated that the language and holding in *Wickline* resulted from regulatory requirements in the Medi-Cal Act that abrogated normal tort responsibility standards.²³³ The *Wilson* court further declared that material issues of fact existed with respect to the defendants' potential liability, and reversed the summary judgment orders.²³⁴ In reaching its decision, the court noted that Western Medical had contracted with Blue Cross of California and not Alabama Blue Cross, and that it was totally unaware of the relevant terms of the policy between Mr. Wilson and Alabama Blue Cross.²³⁵ The relevant provisions of the contract clearly indicated that the decision relating to hospitalization benefits for mental and nervous disorders was to be made by the attending physician.²³⁶ The facts in the record revealed that it was Western Medical Review that told the hospital that costs for further care would not be paid.²³⁷

Most recently, a jury in California awarded an estate over \$85,000,000.00 arising from an HMO's decision to deny a bone marrow transplant to a mother.

226. *Id.* at 880-81.

227. *Id.*

228. *Id.*

229. *Id.* at 878.

230. *Id.* at 880.

231. *Id.* at 879-80, 884.

232. *Id.* at 879-80.

233. *Id.* at 880.

234. *Id.* at 882, 885.

235. *Id.* at 879-81, 883.

236. *Id.* at 880-81.

237. *Id.* at 882.

of three children. The case, *Fox v. Health Net*, reported in the *Newsweek* article referred to above, sent shock waves through the managed care industry.²³⁸ In *Fox*, the HMO refused to approve a bone marrow transplant on the ground that it was investigational, although the contract language arguably indicated otherwise.

In *Wilson* unilateral decisions, unsupported as a result of the policy provisions in the contract issued by Alabama Blue Cross lead to a series of tragic events. The decision made by Western Medical Review may in fact have been correct, if the policy in question had been issued by Blue Cross of Southern California. In *Fox*, vague and ambiguous contract language resulted in disaster, not only for the HMO, but the subscriber and her family as well. Therefore, the lesson from *Wilson*²³⁹ and *Fox* is that consistency and uniformity in contract language, UM review, and processing is a critical function which cannot be ignored. These lessons and others are apparent in the few decisions to date, discussed in the following section.

B. Inappropriate Selection and Decision Making

In *Wilson*, the plaintiff's third amended complaint appeared to contain claims solely related to the defendants' alleged tortious conduct in breaching the contract of insurance between the plaintiff and Alabama Blue Cross.²⁴⁰ Although the claims asserted were, in all likelihood, narrowly focused as a result of the favorable language contained in the controlling contract, if the facts had been slightly different, the plaintiffs could have asserted additional claims. These claims could have included a corporate negligence claim against Blue Cross of Southern California for negligent selection or decision making by the independent UM entity, Western Medical Review, with whom it was under contract. Although to date there is sparse case law directly addressing liability claims arising from cost containment mechanisms in managed care, existing case law dealing with liability claims in the traditional health care setting provide some framework by way of analogy.

Corporate negligence in a health care context is one of many liability theories whose roots are found in the traditional health care delivery setting. This doctrine, first recognized in *Darling v. Charleston Community Memorial*

238. *Fox v. Healthnet*, No. 21962 (Sup. Ct., Riverside County, California).

239. Interestingly, in the six years since its publication, *Wilson* has been cited just twice with respect to issues concerning UM. In both cases the defendants prevailed. See *Steineke v. Share Health Plan of Nebraska*, 518 N.W.2d 904 (Neb. 1994) and *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

240. *Wilson*, 271 Cal. Rptr. at 880-81.

Hospital,²⁴¹ holds that a hospital entity may be liable for negligence arising from its failure to adhere to established regulations and standards created to protect those individuals seeking treatment at its facilities.²⁴² In *Darling*, the plaintiff was taken to the hospital after being injured in a high school football game.²⁴³ The hospital, Charleston Community Memorial, was accredited by the Joint Commission on Accreditation²⁴⁴ and licensed by the state of Illinois.²⁴⁵ Hospital personnel determined that the plaintiff had suffered a broken leg and applied a plaster cast. Shortly thereafter, the plaintiff began to suffer considerable discomfort, which hospital personnel noted.²⁴⁶ The physician who had originally set the cast notched the cast several days later and ultimately split both sides which revealed blood and seepage.²⁴⁷ The plaintiff was transferred to another hospital almost eleven days later where his leg was amputated after unsuccessful efforts to save it.²⁴⁸ The Supreme Court of Illinois, affirming the judgment of the lower court in favor of the plaintiff, determined that the nurses failed to properly attend the plaintiff, the attending physician was not qualified to perform orthopedic procedures, and the hospital failed to set up standards and procedures to confirm compliance with the relevant and controlling regulations, accreditation standards, and bylaws.²⁴⁹

As indicated in *Darling*, and numerous cases which have since followed, a hospital's (or managed care organization's) failure to uphold the proper standard of care it owes to its patients and provide for the safety of those patients may result in liability.²⁵⁰ The underlying basis for this doctrine of corporate liability is that the hospital assumes numerous responsibilities in providing a facility for the treatment of illness. Many of those responsibilities and obligations, as indicated in *Darling*, arise as a result of accreditation standards and statutory requirements.²⁵¹ These standards and requirements include the proper selection of providers who will treat patients in the hospital. Since the *Darling* decision, cases have addressed the issue of negligent selection of providers in the hospital and, recently, in managed care. A majority of these cases have raised corporate negligence claims against hospitals or managed care organizations due to a negligent provider who had

241. 211 N.E.2d 253 (Ill. 1965).

242. *Id.* at 257.

243. *Id.* at 255.

244. *Id.* at 256. This commission is now known as the Joint Commission on Accreditation of Health Care Organizations.

245. *Id.*

246. *Id.* at 255.

247. *Id.*

248. *Id.* at 256.

249. *Id.* at 258.

250. *Id.* at 257-58.

251. *Id.*

been granted staff privileges or appointment to a panel of providers. In the UM context, these cases must be respected and carefully considered when establishing a UM program, contracting with an independent UM entity, or merely monitoring UM for quality control purposes. From the standpoint of selection, UM is increasingly subject to regulation, and, as previously discussed, accreditation standards continue to develop. In light of these developments, a managed care entity's or hospital's failure to follow UM guidelines or due diligence responsibilities could breed disaster.

Although there are presently no reported decisions which have dealt with a claim asserting liability for improper selection or retention of a UM program, the decisions in *Wickline*, *Harrell v. Total Health Care, Inc.*,²⁵² and *McClellan v. Health Maintenance Organization of Pennsylvania*²⁵³ are somewhat analogous, and they provide some guidance in avoiding pitfalls associated with improper selection. As indicated by the court in *Wickline*, liability can arise where a cost containment system is defectively designed or implemented.²⁵⁴ In *Harrell*, the plaintiff asserted several claims, including a corporate negligence claim against Total Health Care, as the result of injuries she suffered due to the malpractice of Dr. Witt.²⁵⁵ Dr. Witt had been appointed by the plaintiff's medical service plan to a panel of providers.²⁵⁶ The service plan, Total Health Care (an IPA model), entered into contracts with physicians to provide care to subscribers whose employers contracted directly or indirectly with Total Health Care.²⁵⁷ As a result of medical complications, plaintiff's primary care physician referred her to Dr. Witt who was listed as a specialist in a publication prepared by Total Health Care. The evidence revealed that Total Health Care conducted no extensive review of those specialists it chose to serve on its provider panel. In fact, no personal interview was conducted, no references check made, and there was no confirmation of the provider's reputation in the community.²⁵⁸ Such precautions would have revealed that Dr. Witt had been sued for malpractice on numerous occasions.²⁵⁹ Plaintiff, in support of her corporate negligence claim, asserted that Total Health Care had a non-delegable duty to plan subscribers to carefully select the providers with whom it contracted so that subscribers would be protected against referrals to

252. 781 S.W.2d 58 (Mo. 1989).

253. *McClellan v. Health Maintenance Org. of Pennsylvania*, 604 A.2d 1053 (Pa. Super. Ct. 1992).

254. *Wickline*, 228 Cal. Rptr. at 670-71.

255. *Harrell*, 781 S.W.2d at 59.

256. *Id.*

257. *Id.* at 59-60.

258. *Harrell v. Total Health Care, Inc.*, No. WD 39809, 1989 WL 153066, *3 (Mo. Ct. App. Apr. 25, 1989).

259. *Id.*

incompetent practitioners.²⁶⁰ In language that clearly implicated managed care arrangements, the court determined that the doctrine of corporate negligence was not limited to hospitals.²⁶¹ In so holding, the court determined that Total Health Care had a duty to its subscribers to conduct a reasonable investigation, and in not doing so, it had failed to discharge its duty to prevent foreseeable harm.²⁶² Although the plaintiff in *Harrel* was ultimately precluded from recovery due to an immunity statute, the decision illustrates the obligations a managed care entity has in carrying out its UM responsibilities.²⁶³

In *McClellan*, a decedent's estate brought corporate negligence, fraud, agency, and breach of contract claims against an HMO and treating physicians for conduct which allegedly caused the decedent's death.²⁶⁴ The decedent had a mole removed from her back by a primary care physician she had selected through the HMO's provider brochure.²⁶⁵ The physician failed to have the mole tested for malignancy.²⁶⁶ The decedent in fact had melanoma and died several years later.²⁶⁷ The claims referred to above were asserted against the physician and the HMO.²⁶⁸ The claims in part were based upon representations of the HMO that "each and every primary care physician provided by [the HMO] satisfied criteria for participation as a qualified physician *after passing vigorous screening criteria*."²⁶⁹ The court held that it was not necessary to extend the doctrine of corporate negligence to an IPA model HMO because the HMO had a non-delegable duty to select and retain competent primary care physicians.²⁷⁰ In so holding, the court was guided by Section 323 of the *Restatement (Second) of Torts* and went on to explain the necessary elements for asserting a claim against an HMO.²⁷¹ The factors the court described are as

260. *Id.*

261. *Id.* at *4.

262. *Id.* at *5.

263. *Harrell v. Total Health Care, Inc.*, 781 S.W.2d 58 (Mo. 1989); *see also* *Insinga v. LaBella*, 543 So. 2d 209 (Fla. 1989) (stating that hospitals are in the best position to protect their patients and consequently, have an independent duty to select and retain competent independent physicians seeking staff privileges); *Blanton v. Moses H. Cone Memorial Hosp.*, 354 S.E.2d 455 (N.C. 1987) (declaring that failure to enforce the standards of the Joint Commission on Accreditation of Hospitals is some evidence of a hospital's negligence in a corporate context); *Johnson v. Misericordia Community Hosp.*, 301 N.W.2d 156 (Wis. 1980) (holding that failure to investigate a medical staff applicant's qualifications for requested privileges gives rise to a foreseeable risk of unreasonable harm and a hospital has a duty to exercise due care in the selection of its medical staff).

264. *McClellan*, 604 A.2d at 1055-56.

265. *Id.* at 1055.

266. *Id.*

267. *Id.*

268. *Id.*

269. *Id.* at 1057 (emphasis added).

270. *Id.* at 1059.

271. *Id.*

follows: to render services to the plaintiff subscriber; which the HMO should recognize as necessary for the protection of its subscriber; that *the HMO failed to exercise reasonable care in selecting, retaining, and/or evaluating* the plaintiff's primary care physician, and, that as a result of the HMO's failure to use such reasonable care, the risk of harm to the subscriber was increased.²⁷²

Improper decision making in a UM context was also implicated as a potential area of concern for managed care organizations as a result of the *Wickline* decision.²⁷³ As indicated by the court, liability may result where appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.²⁷⁴ In addition to the corporate negligence cases discussed above, cases which provide guidance include bad faith claims asserted against insurance companies arising from their decisions to deny coverage to their insureds.²⁷⁵ For example, in *Hughes v. Blue Cross of Northern California*²⁷⁶ an insured under a group health plan asserted bad faith claims against the insurer for denying coverage for psychiatric hospitalization for her son.²⁷⁷ The evidence at trial revealed a UM program in disarray that reflected "established company practice" according to the court.²⁷⁸ In *Hughes*, the factors which lead to a finding that Blue Cross had acted in bad faith included a UM process which relied upon a cursory review of fragmentary records, the consultant's disclaimer of any obligation to investigate, use of a standard of "medical necessity" at variance with community standards, and uninformative follow-up letters which were sent to treating physicians.²⁷⁹ In *Rederscheid v. Comprefcare, Inc.* the plaintiff was permitted to assert a breach of contract and bad faith claim against her HMO as a result of its failure to pay for corrective oral and jaw surgery.²⁸⁰

Foreseeable claims arising from UM decisions could also be based upon many of the factors outlined in the *Hughes* case, including a failure to review complete and accurate records,²⁸¹ failure to communicate with the attending

272. *Id.*

273. *Wickline*, 228 Cal. Rptr. at 670-71.

274. *Id.*

275. PATRICIA A. YOUNGER ET AL., *MANAGED CARE LAW MANUAL, BASIS FOR LIABILITY* 12-13 (1995).

276. 263 Cal. Rptr. 850 (Cal. Ct. App. 1989).

277. *Id.*

278. *Id.* at 858.

279. *Id.*

280. 667 P.2d 766 (Colo. Ct. App. 1983).

281. *Schleier v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.*, 876 F.2d 174 (D.C. Cir. 1989); *see also* *Aetna Life Ins. Co. v. Lavoie*, 505 So. 2d 1050 (Ala. 1987) (evidencing that health insurer's denial of claim, disputing reasonable necessity of insured's hospitalization, without benefit of progress notes and nurses' notes, was sufficient to sustain finding of bad faith refusal to pay claim); *Taylor v. Prudential Ins. Co.*, 775 F.2d 1457 (11th

physician prior to making a coverage decision,²⁸² decisions which are arbitrary and cannot in good faith be supported,²⁸³ and failure to notify a subscriber of his or her right to appeal an adverse decision.²⁸⁴

As seen from the decisions referenced above, the doctrine of corporate negligence is potentially a viable claim for plaintiffs to assert in situations where inappropriate UM selection, retention, monitoring or decision making has taken place. Other claims may include breach of contract/bad faith,²⁸⁵ respondeat superior,²⁸⁶ fraud and misrepresentation,²⁸⁷ and apparent or ostensible agency.²⁸⁸ Whatever the claim, managed care entities can best protect themselves and their subscribers by being constantly attentive to the UM process through strict quality control. Steps that can help avoid improper UM selection or decision making liability claims include, but are not limited to, the following: confirmation of licensing and accreditation; adherence to unambiguous UM standards and policies; selection of competent reviewers; continuing education programs for reviewers; taking all precautions necessary to ensure that reviewers do not interfere with the provider's responsibility for making patient treatment decisions; allowing decisions to be made by only those personnel who are qualified to consider the medical issue at hand; proper review of complete and relevant records; second opinion procedures; attending physician approval of UM decision where feasible; accurate contractual and marketing material; appropriate subscriber notification procedures; and effective appeal and review procedures.²⁸⁹

Cir. 1985).

282. *Linthicum v. Nationwide Life Ins. Co.*, 723 P.2d 675 (Ariz. 1986).

283. *Wickline*, 228 Cal. Rptr. at 670-71.

284. *Sarchett v. Blue Shield of California*, 729 P.2d 267 (Cal. 1987); *Williams v. HealthAmerica*, 535 N.E.2d 717 (Ohio Ct. App. 1987).

285. See *McClellan v. Health Maintenance Org. of Pennsylvania*, 604 A.2d 1053 (Pa. 1992); *Fox v. Health Net*, No. 21962 (Cal. App. Dep't Super. Ct.); *Hedrick v. Sanus Texas Health Plan, Inc.*, No. 2864 (Tex. Dist. Ct. 18th Judicial, May 1991).

286. *Sloan v. Metropolitan Health Council of Indianapolis, Inc.*, 516 N.E.2d 1104 (Ind. Ct. App. 1987) (finding a material issue of disputed fact existed as to whether there were usual requisites of agency or employer-employee relationship between HMO and employee-physician precluded summary judgment as to whether HMO was vicariously liable for physicians alleged malpractice).

287. *Boyd v. Albert Einstein Medical Ctr.*, 547 A.2d 1229 (Pa. Super. Ct. 1988).

288. *Id.* at 1234-35; see also *Dunn v. Praiss*, 656 A.2d 413 (N.J. 1995).

289. *Dowell*, *supra* note 98, at 127-30; *BENDA*, *supra* note 112, at § 12. The National Association of Insurance Commissioners has recently developed model laws pertaining to utilization review entitled, *Utilization Review Model Act*, reprinted in N.A.I.C. MODEL LAWS, REGULATIONS & GUIDELINES, vol. I, at I-73 to I-12.

VII. FINANCIAL INCENTIVE ARRANGEMENTS BETWEEN HEALTH-CARE PROVIDERS AND PAYERS: THE ISSUE OF POTENTIAL LIABILITY

An additional area of potential liability results from financial incentive arrangements between health care providers and payers. The potential for liability arising from various financial incentives and arrangements between managed care organizations and providers has been the subject of numerous articles.²⁹⁰ Although the various arrangements discussed in section IV above and potential liability claims that arise from such arrangements may at first seem appealing to plaintiffs' lawyers and critics of managed care, the courts have to date unanimously rejected them as a matter of law. Importantly, studies have revealed that the quality of care does not tend to differ for those treated in pre-paid health plans as compared to traditional fee-for-service health care.²⁹¹

Most of the legal opinions have indicated that the regulation or prohibition of financial incentives is an area of exclusive legislative concern or that such incentives do not override the provider's ethical and legal duty to the patient.²⁹² For example, in *McClellan* the plaintiff attempted to attack the heart of managed care, alleging that the agreements between the HMO and its primary care physicians were tortious. Specifically, the plaintiff claimed that as a result of system design, which included a capitation arrangement between the HMO and its panel of providers, it was against the primary care physicians personal and pecuniary interest to give proper medical advice and make appropriate

290. See David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141 (1995); Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241 (1995); E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719 (1987).

291. See Orentlicher, *supra* note 290, at 161-66. See Dolores G. Clement et al., *Access and Outcomes of Elderly Patients Enrolled in Managed Care*, 271 JAMA 1487 (1994) (noting that there were no differences in outcome between the HMO and fee-for-service patients with chest pain); Paula Braveman et al., *Insurance-Related Differences in the Risk of Ruptured Appendix*, 331 NEW ENG. J. MED. 444 (1994) (showing that HMO patients receive more preventive tests and examinations than patients who subscribe to traditional fee-for-service plans for their health care coverage).

292. See Edward B. Hirshfeld, *Should Ethical and Legal Standards For Physicians Be Changed To Accommodate New Models For Rationing Care?*, 140 U. PA. L. REV. 1809 (1992); *Paul v. Humana Medical Plan, Inc.*, 682 So. 2d 1119 (Fla. 4th DCA 1996). The court rejected plaintiff's assertion that capitation arrangement between physicians and HMO caused physicians to avoid providing additional care to plaintiff allowed for a claim of intentional infliction of emotional distress. *Id.* The court found that even if such conduct on the part of the physicians occurred, the only claim plaintiffs could assert against the physicians would be medical malpractice. *Id.*

referrals. In language worth quoting in its entirety, the court in its analysis rejected the plaintiff's claim for the following reasons:

This allegation suggests as issues whether the essential elements of the HMO system violate public policy, and whether the HMO system itself contributed to the asserted malpractice in this case. It is settled beyond peradventure, however, that the judicial branch is precluded by constitutional mandate from addressing the ethical, moral, or social implications of a health care program which indirectly provides a diminished compensation for a provider who deems further medical attention necessary or desirable. The fundamental prerogative and duty of considering and establishing social policy, including, of course, the regulation of health care providers, is vested solely in the legislature.²⁹³

Although decided at an early stage in the litigation,²⁹⁴ it is hard to imagine that the physician (purportedly corrupted by a financial incentive system, if any, in place) in *McClellan*, other than making a terrible mistake, did so in order to avoid spending the approximately \$200 to \$300 dollars it would have cost to perform the appropriate histology. The provider has simply too much at stake to take such a risk. Such risks include a potential malpractice claim, being referenced in the National Practitioner Data Bank, revocation of privileges, or all of the foregoing. It is well recognized that a physician is a fiduciary, and thus any financial or ethical conflict must be resolved in favor of the patient.²⁹⁵

However, it appears that for a minority of providers, full reimbursement is of greater concern than patient welfare. The court addressed this issue in *Varol v. Blue Cross & Blue Shield of Michigan*.²⁹⁶ In *Varol*, psychiatrists participating in a pilot program providing mental health services to union members sought relief in the district court, alleging that the programs requirements of pre-authorization review and other managed care obligations violated Michigan law and deprived the physicians of other due process rights.²⁹⁷ The physicians complained that the pre-authorization review

293. *McClellan*, 604 A.2d at 1056 n.6. See also *Teti v. U.S. Healthcare Inc.*, Civ. A. Nos. 88-9808, 88-9822, 1989 WL 143274 (E.D. Pa. Nov. 21, 1989), *aff'd*, 904 F.2d 696 (3d Cir. 1990) (affirming dismissal of a complaint asserting RICO claims on an HMO's concealment of a compensation referral fund).

294. *McClellan*, 604 A.2d at 1054-56. The HMO's motion to dismiss the plaintiff's claims were granted by the trial court. *Id.*

295. Rodwin, *supra* note 290, at 246.

296. 708 F. Supp. 826 (E.D. Mich. 1989); *contra* *Bush v. Dake*, No. 86-25767NM-2 (Mich. Cir. Ct. April 27, 1989). In *Bush*, the plaintiff alleged that her cancer would have been diagnosed sooner but for certain financial incentives to reduce utilization established between the HMO and her treating physician. *Id.*

297. *Varol*, 708 F. Supp. at 826, 834.

procedure interfered with their right and obligation to determine the methods of diagnosis and treatment for patients.²⁹⁸ In addition, the physicians argued that the threat that they would not be paid or only partially paid would unfairly influence them to render treatment other than what the provider in good faith believed should be offered.²⁹⁹ In absolutely rejecting the argument against the establishment of the UM program in question (or financial incentive arrangements between health care providers and payers), the court engaged in the following dialogue:

Irrespective of any obligation I have to my patients and to my profession, my judgment as to what is in the best interests of my patients will not be determined by the exercise of my medical judgment, but by how much I will be paid for my services. Plaintiffs are saying in effect, "Since I am weak in my resolve to afford proper treatment, Blue Cross's pre-authorization program would induce me to breach my ethical and legal duties, and the court must protect me from my own weakness." In other words protect me from my own misconduct. This is strange stuff indeed from which to fashion a legal argument. After all, the program is designed to make certain that only medically necessary services are provided and paid for. This is a legitimate objective, whether applied to a post-service reimbursement program or a concurrent review and pre-authorization program. . . . Cost containment in any program must deal with policing the necessity of the services rendered and payment therefore. GM and the U.A.W. are entitled to join together to make that effort. And it appears altogether inappropriate for the plaintiffs to say that the program will induce them to breach their duties to their patients.³⁰⁰

For the very small number of providers that fall in this category, managed care organizations must carry out a very intensive screening process to avoid selection of these individuals. For those who slip through the process, practice patterns must be constantly reviewed in an effort to detect questionable medical decisions and, for those who engage in such conduct, notification of the proper professional licensing boards is in order.³⁰¹ Legislatures and government agencies are also free to establish reasonable rules and regulations as suggested by the court in *McClellan*.³⁰² Recently, the Department of Health and Human Services published a proposed final rule which would prohibit Medicare and

298. *Id.* at 831.

299. *Id.*

300. *Id.* at 833.

301. One school of thought is that the managed care organization should be required to disclose to its members any existing physician financial incentive arrangements. See McGraw, *supra* note 71, at 1836-39.

302. *McClellan*, 604 A.2d at 1056, n.6.

Medicaid managed care plans from making specific payments to providers to limit or reduce medically necessary services to a specific enrollee.³⁰³ The rule would also require that the plan disclose to the Health Care Financing Administration or state Medicaid agency physician incentive plans, and upon a plan subscriber's request, provide a summary of plan benefits.³⁰⁴

To attack any form of financial incentive arrangement program with health care providers as a per se violation of the standard of care misses the point. As indicated in the *Wilson* decision, a managed care entity can no longer lay all the blame at the feet of the provider when things go awry.³⁰⁵ That being the case, it is the providers ethical and professional obligation, as indicated in *Varol*, to provide competent and proper care.³⁰⁶ If in doing so, a UM decision is made that is not based upon established criteria and standards, but upon financial considerations alone, then the managed care organization as a corporate entity may potentially suffer the liability consequences, subject to the preemptions discussed in the next section.³⁰⁷

VIII. THE IMPACT OF THE EMPLOYEE RETIREMENT INCOME AND SECURITY ACT ON EMERGING LIABILITY CLAIMS (ERISA)

ERISA was enacted by Congress in 1974 in order to protect participants in employee benefit plans and their beneficiaries. These goals were to be

303. Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 61 Fed. Reg. 13,430 (1996). Section 417.479(2)(d) entitled "Prohibited Physician Payments" states as follows:

No specific payment of any kind may be made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit covered medically necessary services covered under the organization's contract furnished to an individual enrollee. Indirect payments include offerings of monetary value (such as stock options or waivers of debt) measured in the past or future.

Id.

304. *Id.*

305. *Wilson v. Blue Cross of California*, 271 Cal. Rptr. 876 (Cal. Ct. App. 2d Dist. 1990).

306. *Varol v. Blue Cross & Blue Shield of Michigan*, 708 F. Supp. 826, 833-34 (E.D. Mich. 1989).

307. Sherry Boschert, "Corporatization" May Take Liability Heat Off MDs, INTERNAL MEDICINE NEWS, vol. 67, no. 29, March 1, 1996. Stating:

Increasing 'corporatization' of health care may shift malpractice lawsuits away from physicians and incline juries to reach deep into the pockets of faceless health systems. . . . Some potential advantages of integrated health care enterprises might lead to a reduction in the number of malpractice suits filed in the future. Total quality management plans, practice protocols, and utilization review could improve the quality of care. A stronger ability to develop communication links and implement information technologies also might nip some problems in the bud.

Id. at 67. See also Bruce Japson, *Balancing Risk*, 26 MODERN HEALTHCARE 44, Oct. 28, 1996, at 41-46 (discussing the trend of hospitals and health systems attempting to bring physicians under the same professional liability umbrella).

achieved by requiring the disclosure and reporting of financial and other information and the establishment of standards of conduct for fiduciaries of employee benefit plans. ERISA established for employees and their beneficiaries appropriate remedies, sanctions, and access to the federal courts.³⁰⁸ In addition to protecting employee benefit plan participants and beneficiaries, ERISA was enacted to replace the overlapping scheme of state regulation of employee benefit plans with a uniform set of federal regulations.³⁰⁹ In the managed care arena, ERISA is particularly important in that it has provided some protection from liability claims purportedly arising from UM and other cost containment activities. Before reviewing relevant legal decisions, a review of the controlling ERISA provisions is in order.

In relevant part, ERISA defines an "*employee welfare benefit plan*" as including:

any plan, fund, or program that was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program *was established or is maintained for the purpose of providing* for its participants or their beneficiaries, through the purchase of *insurance or otherwise medical, surgical, or hospital care or benefits*.³¹⁰

ERISA applies to "any employee benefit plan if it is established or maintained by an employer engaged in commerce or in any industry or activity affecting commerce."³¹¹ Employee welfare benefit plans which fall outside of the scope of ERISA are identified in United States Department of Labor regulations as:

a group or group-type insurance program offered by an insurer to employees or members of an employee organization under which: (1) no contributions are made by an employer or employee organization; (2) participation [in] the program is completely voluntary for employees or members; (3) the sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions and to remit them to the insurer; and, (4) the employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than

308. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

309. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

310. 29 U.S.C. § 1002(1)(A) (1994) (emphasis added).

311. 29 U.S.C. § 1003(a)(1) (1994).

reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions.³¹²

The existence of an ERISA plan is a question of fact to be resolved in light of all surrounding facts and circumstances from the point of view of a reasonable person.³¹³ Case law indicates that an employer may have (but has not necessarily) established an ERISA plan if its main involvement is to contribute to the payment of the premiums. If the employer does not contribute to the premiums, but merely transmits the employee's premiums without endorsing the policy or profiting from the program, no ERISA plan has been established. However, whether the employer contributes premiums or not, if it has endorsed the program in the sense that the employer is significantly involved in it, an ERISA plan may have been established. The ultimate determination depends on an evaluation of all the circumstances, keeping in mind ERISA's purpose of regulating an employer's administration of benefit plans.³¹⁴ Employee coverage through an HMO falls under ERISA if the program through which the coverage was obtained is sponsored by an employer.³¹⁵

The critical provisions of ERISA which are of importance to managed care organizations are contained in the preemption clause.³¹⁶ The preemption clause of ERISA preempts all state laws that *relate to* employee benefit plans whether or not the state laws are designed to affect employee benefit plans. The United States Supreme Court in *Ingersoll-Rand Co. v. McClendon* indicated that the phrase "relate to" expands preemption beyond state laws that relate to the specific subjects covered by ERISA, such as reporting, disclosure and fiduciary obligations.³¹⁷ The Tenth Circuit in *Airparts Company v. Custom Benefit Services of Austin, Inc.* identified the following four categories of laws which relate to an employee benefit plan:

312. 29 C.F.R. § 2510.3-1(j) (1994).

313. *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982).

314. *Rizzi v. Blue Cross of Southern California*, 253 Cal. Rptr. 542, 547 (Cal. Ct. App. 4th Dist. 1989).

315. *Scullion v. Travelers Health Network*, 720 F. Supp. 530 (W.D. Pa. 1989).

316. 29 U.S.C. § 1144 (1994). There are two types of ERISA preemption. First, conflict preemption wherein federal law supersedes state law which relates to employee benefit plans. The second type of preemption is complete preemption, concerning certain claims involving the enforcement or clarification of benefit rights and plan administration. In *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996), a district court ruled that only complete preemption creates federal jurisdiction. According to the court in *Prihoda*, when the complete preemption doctrine is inapplicable, but the lawsuit contains a state law claim that is potentially preempted under conflict preemption, the lawsuit cannot be removed to federal court, rather the preemption defense must be resolved in the state court proceedings. *Id.* at 118.

317. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137-40 (1990).

(i) laws that regulate the type of benefits or terms of ERISA plans; (ii) laws that create reporting, disclosure, funding, or vesting requirements for ERISA plans; (iii) laws that provide rules for the calculation of the amount of benefits to be paid under ERISA plans; and, (iv) laws and common-law rules that provide remedies for misconduct growing out of the administration of the ERISA plan.³¹⁸

The effect of the preemption clause, savings clause, and deemer clause must be considered in deciding whether a particular state law claim is preempted under ERISA. The *preemption clause* provides that:

except as provided in subsection (b) of this section [the savings clause] the provisions of this Title and Title IV *shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in [section 1003 (a)] and not exempt under [section 1003 (a)]*.³¹⁹

The *savings clause* in relevant part states that "except as provided in subparagraph (B) [the deemer clause] *nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities*."³²⁰ Finally, the *deemer clause* provides that:

*neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.*³²¹

In considering the three provisions above, the United States Supreme Court established the appropriate test in *Pilot Life Insurance Co. v. Dedeaux*.³²² The Court held that one must analyze whether the state statutory claims or common law claims asserted in the lawsuit *relate to* an employee benefit plan and thus fall within ERISA's preemption clause.³²³ The Supreme Court in *Ingersoll-Rand* provided more guidance when it held that a law would relate to an employee benefit plan when it has a connection with or reference to such

318. *Airparts Co. v. Custom Benefit Servs. of Austin, Inc.*, 28 F. 3d 1062, 1064-65 (10th Cir. 1994).

319. 29 U.S.C. § 1144(a) (1994) (emphasis added).

320. 29 U.S.C. § 1144(b)(2)(A) (1994) (emphasis added).

321. 29 U.S.C. § 1144(b)(2)(B) (1994) (emphasis added).

322. 481 U.S. 41 (1987).

323. *Id.* at 47.

a plan.³²⁴ Under this analysis, a law will be preempted under ERISA even though it was not intended to affect such a plan or the effect is only incidental. With respect to common law claims such as breach of contract or negligence, these claims as well will be preempted if they relate to an employee benefit plan and do not come within any of the ERISA exemptions.³²⁵

Under ERISA, a participant's or beneficiary's remedies are limited to the recovery of benefits, enforcement of rights, or the clarification of future benefits under the plan.³²⁶ Thus, claims which seek compensatory or punitive damages will not be permitted if they come within the provisions outlined above. This is particularly important for managed care organizations, administrators, and employers who are striving to maintain quality health care at affordable rates. With respect to cost containment mechanisms such as UM, several courts, including those in *Corcoran v. United Healthcare, Inc.*,³²⁷ *Tolton v. American Biodyne, Inc.*,³²⁸ and *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*³²⁹ have decided that liability claims based on a purported negligent or improper decision relating to a plan participant's eligibility for benefits, are preempted by ERISA.

In *Corcoran*, a wrongful death claim alleging that the defendants were responsible for the death of the plaintiff's unborn fetus was filed in state court against Blue Cross of Alabama and United Healthcare.³³⁰ The plaintiff, Florence Corcoran, was an employee of a telephone company and received health benefits through a plan funded by her employer and administered by Blue Cross of Alabama.³³¹ The plan required pre-certification review for designated medical procedures and overnight hospital stays.³³² Corcoran's employer contracted with United Healthcare to perform the utilization review function on its behalf.³³³ During her pregnancy, Corcoran experienced complications which lead her physician to recommend complete bed rest for the remainder of her pregnancy.³³⁴ United Healthcare determined that hospitalization was unnecessary, and authorized ten hours a day of home

324. *Ingersoll-Rand Co.*, 498 U.S. at 138-39.

325. 29 U.S.C. § 1144(b) (1994).

326. 29 U.S.C. § 1132(a)(1)(B) (1994).

327. 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).

328. 48 F.3d 937 (6th Cir. 1995).

329. 999 F.2d 298 (8th Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994).

330. *Corcoran*, 965 F.2d at 1324.

331. *Id.* at 1323.

332. *Id.* at 1323.

333. *Id.*

334. *Id.* at 1322.

nursing care.³³⁵ The fetus went into distress and died at a time when no nurse was on duty.³³⁶

The original state court lawsuit was removed to federal court by United Healthcare, and later dismissed by the district court on the basis that the claims were preempted by ERISA.³³⁷ Corcoran appealed the dismissal to the Fifth Circuit Court of Appeals, which affirmed. On appeal, the Corcorans argued that *Pilot Life Insurance* was inapplicable in that the tort claims asserted were based upon an improper medical decision, and not upon the improper processing of benefits.³³⁸ Corcoran argued that in *Independence HMO, Inc. v. Smith*, the federal district court held that ERISA did not preempt medical malpractice claims.³³⁹ The court in rejecting Corcoran's argument determined that although United Healthcare gave medical advice, it did so while deciding what benefits were available to the plan subscriber.³⁴⁰ Thus, the court applied 29 U.S.C. § 1144 of ERISA, which mandated preemption of Corcoran's claims.³⁴¹

In *Tolton*, an action was brought in state court on behalf of the decedent, arising from a claimed improper denial of benefits.³⁴² The decedent, Henry Tolton was employed by United Way-Big Brothers/Big Sisters of Greater Cleveland.³⁴³ United Way provided group health insurance to Tolton through Connecticut General Life Insurance Company.³⁴⁴ This plan was administered by CIGNA Health Plan of Ohio ("CIGNA") pursuant to a managed care option.³⁴⁵ There was no dispute that the plan was a qualified employee benefit plan pursuant to ERISA.³⁴⁶ CIGNA contracted with American Biodyne to provide mental health benefits to plan participants.³⁴⁷ The facts in the record revealed that Tolton was addicted to drugs and sought evaluation and treatment from American Biodyne.³⁴⁸ Approximately four months after first seeking treatment, Tolton committed suicide.³⁴⁹ Tolton's state law action included

335. *Id.* at 1324.

336. *Id.*

337. *Id.* at 1324-26.

338. *Id.* at 1330.

339. *Id.* at 1333, n.16. See *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990).

340. *Corcoran*, 965 F.2d at 1332.

341. *Id.* at 1338.

342. *Tolton*, 48 F.3d at 940-41.

343. *Id.* at 939.

344. *Id.* at 939.

345. *Id.*

346. *Id.*

347. *Id.*

348. *Id.* at 940.

349. *Id.*

wrongful death, improper refusal to authorize benefits, medical malpractice, and insurance bad faith claims.³⁵⁰ These claims all arose from American Biodyne's refusal to authorize psychiatric benefits to Tolton under the plan. Affirming the entry of a summary judgment against Tolton, the circuit court determined that utilization review was a means of processing claims, and as a result the negligence claim was preempted under the provisions of ERISA.³⁵¹ In addition the court also rejected Tolton's bad faith claims relying on *Pilot Life Insurance* wherein the Supreme Court held that a bad faith claim arising from the processing of benefits was preempted by ERISA.³⁵² In *Pilot Life Insurance* the Supreme Court held that an insurance bad faith claim was not preserved under ERISA's savings clause in that it was derived from tort and contract principles and not directed exclusively at the insurance industry.³⁵³ The Supreme Court also decided that a bad faith claim did not fall within the *McCarran-Ferguson Act's*³⁵⁴ definition of the "business of insurance" in that such claims did not spread risk and only indirectly affected the relationship between the insurer and insured.³⁵⁵

Finally, in *Kuhl*, Belger Cartage Services employee health plan was administered by Lincoln National Health Plan.³⁵⁶ The health plan was a network model HMO.³⁵⁷ Under the provisions of the plan, Lincoln National was not required to pay for medical services rendered outside of the service area.³⁵⁸ In addition, the plan had a UM program in place that conducted pre-certification review.³⁵⁹ In 1989, Mr. Kuhl, who was an employee of Belger Cartage Services and covered under the employee health plan, suffered a heart attack.³⁶⁰ After extensive examination, Mr. Kuhl's physicians determined that it was necessary for him to undergo heart surgery as soon as possible. Because Kansas City area hospitals did not have the proper equipment to conduct the surgery, the physicians recommended that Mr. Kuhl travel to Barnes Hospital in St. Louis.³⁶¹ The surgery was scheduled for July 6, 1989.³⁶² Prior to the surgery, Lincoln National contacted Mr. Kuhl and informed him that the surgery would not be paid for, as the surgery was to be performed outside of

350. *Id.* at 939.

351. *Id.* at 941-43.

352. *Id.* at 942 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987)).

353. *Tolton*, 48 F.3d at 942.

354. *Id.*; see 15 U.S.C. §§ 1011-1015 (1994).

355. *Id.*; see *Pilot Life Ins.*, 481 U.S. at 50-51.

356. *Kuhl*, 999 F.2d at 299.

357. *Id.*

358. *Id.*

359. *Id.*

360. *Id.* at 300.

361. *Id.*

362. *Id.*

the service benefit area.³⁶³ Lincoln National thereafter scheduled Mr. Kuhl to be examined for a second opinion.³⁶⁴ The physician who examined Mr. Kuhl determined that the surgery was indeed necessary. On July 20, 1989, Lincoln National informed Mr. Kuhl that he could proceed with the surgery in St. Louis.³⁶⁵ Unfortunately, the surgeons could not reschedule until September. In September, Mr. Kuhl was examined shortly before his surgery at which time it was determined that surgery was no longer a viable option. Mr. Kuhl was then placed on the transplant waiting list.³⁶⁶ However, Mr. Kuhl died before a donor was located.³⁶⁷ Mr. Kuhl's family brought suit against Lincoln National in state court, alleging that Lincoln National committed medical malpractice, among other claims. Lincoln National removed the case to the federal district court pursuant to ERISA.³⁶⁸ Thereafter, the court granted Lincoln National's motion for summary judgment determining that the Kuhl's claims were preempted under ERISA in that they related to the administration of the employer health plan.³⁶⁹ On appeal, the Eighth Circuit rejected the Kuhl's argument that Lincoln National assumed the role of Mr. Kuhl's physician and made improper decisions concerning his care.³⁷⁰ Further, the Kuhls alleged that Lincoln National took on the role of physician by "cancel[ing]" Mr. Kuhl's first scheduled surgery in July of 1989.³⁷¹ The court rejected this argument as well, holding that Lincoln National's decision not to pre-certify payment for the surgery related directly to its obligation to administer benefits on behalf of Mr. Kuhl's employer.³⁷² However, it is critical for managed care organizations to note that the court did indicate that under different facts, the cancellation of a beneficiary's surgery by an ERISA benefits provider could result in a non-preempted state law claim.³⁷³ The distinction the court attempted to make in *Kuhl* is that under such circumstances, the managed care organization has assumed the role of an arranger of health care or unquestionably interfered with or assumed the medical professional's decision making role.

363. *Id.*

364. *Id.*

365. *Id.*

366. *Id.*

367. *Id.* at 298-300.

368. *Id.* at 300-01.

369. *Id.* at 301.

370. *Id.* at 302.

371. *Id.* at 303.

372. *Id.*

373. *Id.* (stating, "We do not imply that how the surgery was canceled would be immaterial in every case. In a different case, the cancellation of a beneficiary's surgery by an ERISA benefits provider may lay the basis for non-preempted state law claims.").

The Third Circuit in *Dukes v. U.S. Healthcare, Inc.*³⁷⁴ held that under the well-pleaded complaint rule ERISA does not act to preempt state law claims against an HMO for medical negligence where the claims did not question a denial of benefits, but rather the quality of benefits received.³⁷⁵ In *Dukes*, the court consolidated two cases involving claims which had been asserted against U.S. Health Care Systems of Pennsylvania, Inc. and the Health Maintenance Organization of Pennsylvania/New Jersey (collectively the "HMO").³⁷⁶ In the first case consolidated by the court, the plaintiff, Cecilia Dukes filed a claim in a Pennsylvania state court against numerous defendants, including United States Health Care Systems of Pennsylvania, Inc., a federally qualified HMO which had been organized by U.S. Healthcare.³⁷⁷ The lawsuit arose as a result of the death of Cecilia Dukes's husband, Darryl Dukes.³⁷⁸ In the lawsuit, Mrs. Dukes alleged that the HMO which provided treatment to her husband was responsible under a negligent selection and monitoring theory and ostensible agency theory, for the negligent actions of the various doctors and other medical-service providers who cared for her husband shortly before his death.³⁷⁹ The HMO removed the case to the district court which ultimately dismissed the claims against the HMO pursuant to the preemption provisions of ERISA, and remanded to the state court the remaining claims against the individual defendants.³⁸⁰ In the second case consolidated by the court, Ronald and Linda Visconti also filed suit in a Pennsylvania state court against the HMO under ostensible and actual agency theories, asserting that the HMO held out the treating physician as a competent and qualified obstetrician-gynecologist.³⁸¹ The couple filed suit after Mrs. Viscontis's physician allegedly failed to properly treat symptoms typical of preeclampsia resulting in the death of

374. 57 F.3d 350, 353-54 (3d Cir. 1995). "Under the well-pleaded complaint rule, a cause of action 'arises under' federal law, and removal is proper, only if a federal question is presented on the face of the plaintiff's properly pleaded complaint. A federal defense to a plaintiff's state law cause of action ordinarily does not appear on the face of a well-pleaded complaint, and, therefore, usually is insufficient to warrant removal to federal court. Therefore, the defense of preemption is usually insufficient basis to remove a case from state to federal court." *Id.* (internal citation omitted). An exception to the well-pleaded complaint rule applies where complete preemption results from an act of Congress which completely preempts a particular area of law. "The Supreme Court has determined that Congress intended that the complete preemption doctrine apply to state law causes of action which fit within ERISA's civil enforcement provisions at 29 U.S.C. § 1132(a) (1994)." *Id.*

375. *Dukes*, 57 F.3d at 355-61.

376. *Id.* at 353.

377. *Id.* at 352.

378. *Id.*

379. *Id.*

380. *Id.* at 353. See *Dukes v. United States Health Care Sys., Inc.*, 848 F. Supp. 39, 42 (E.D. Pa. 1994).

381. *Dukes*, 57 F.3d at 353.

their child.³⁸² Again, as in Mrs. Dukes's case, the HMO removed the case to the district court which ultimately dismissed the claims against the HMO pursuant to the preemption provisions of ERISA.³⁸³ The plaintiffs' appealed, and after consolidating the two cases the Third Circuit reversed. Although the *Dukes* opinion at first glance appeared to sound the death-knell for the UM administration and benefit review preemption under ERISA, the court did not go quite so far. The court noted that the plaintiffs were not claiming that their welfare plans refused to pay or provide medical services, but rather, that the plan provided low quality medical care.³⁸⁴ Thus the court indicated it was confident that a claim attacking the quality of benefits was not a claim under ERISA to recover "benefits due . . . under the terms of [the] plan."³⁸⁵ On this precise issue, relying on *Kuhl* and *Corcoran* the court noted the distinctions between *utilization review* and *arranging for medical treatment*, holding that only *utilization review* will trigger the preemption provisions of ERISA.³⁸⁶ In

382. *Id.*

383. *Id.*; see *Visconti ex rel. Visconti v. U.S. Health Care*, 857 F. Supp. 1097, 1105 (E.D. Pa. 1994).

384. *Dukes*, 57 F.3d at 357. In *Roessert v. Health Net*, 929 F. Supp. 343, 350-51 (N.D. Cal. 1996), the district court citing *Dukes* held that ERISA did not preempt negligence claims against an HMO for negligently advising a participating medical group to assist in the psychiatric commitment of one of the HMO's subscribers, without appropriate consent from the subscriber's spouse. The district court reasoned that the HMO's advice and the claim of negligence were not related to benefits or enforcement of rights under the employee benefit plan, but rather directed against the quality of benefits received. *Roessert*, 929 F. Supp. at 350-51.

385. *Dukes*, 57 F.3d at 358; see 29 U.S.C. § 1132(a)(1)(B) (1988). Recently in *In re Estate of Robert Frappier, Jr. v. Wishnov*, 678 So. 2d 884 (Fla. Dist. Ct. App. Aug. 21, 1996) the court held that ERISA did not preempt vicarious liability claims against an HMO. *Id.* at 887 (citing *Dukes v. United States Health Care Sys., Inc.*, 848 F. Supp. 39 (E.D. Pa. 1994)). And in *Quellette v. Christ Hospital*, 942 F.Supp. 1160 (S.D. Ohio 1996), the court relied on *Dukes* to find that ERISA did not preempt an HMO subscriber's claims that financial incentive arrangements between the HMO and its providers had the effect of undermining the quality of care administered.

386. *Dukes*, 57 F.3d at 360-61. The court in *Dukes* did state that its holding was limited to certain fact scenarios. See also *Rice v. Hall*, 65 F.3d 637 (7th Cir. 1995) (stating that members' malpractice claims against two doctors, and health plan administrator for malpractice under a state law *respondeat superior* theory were not subject to complete preemption under ERISA); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995) (stating that ERISA did not preempt a state law claim that an HMO was vicariously liable for alleged medical malpractice of one of its physicians when the claim did not involve administration of benefits or the level or quality of benefits promised by the plan, but rather, reference to the plan to determine the issue of agency with respect to the HMO and the physician); *Prudential Health Care Plan, Inc. v. Lewis*, 1996 WL 77018, No. 95-6255 (10th Cir. Feb. 21, 1996) (stating that just as ERISA does not preempt a malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO, if the HMO has held out the doctor as its agent); *Cannon v. Group Health Serv. of Oklahoma, Inc.*, 77 F.3d 1270 (10th Cir. 1996) (stating that despite the preemption of state law damage claims resulting in the unavailability of a remedy under ERISA, a health plan beneficiary is not denied access to justice in violation of the Fifth

so finding, the court indicated that it is only in the *utilization review* role that an entity is in a position to deny benefits due under an ERISA welfare plan.³⁸⁷

Finally, the Supreme Court in *Varity Corp. v. Howe* determined that the language in § 1132(a)(3) did in fact allow individual beneficiaries to sue for relief under ERISA.³⁸⁸ In *Varity Corp.*, the plaintiffs were former employees of Massey-Ferguson, Inc. and its wholly-owned subsidiary, Varity Corporation (Variety).³⁸⁹ The employees of these two entities were participants in, and beneficiaries of, Massey-Ferguson's self-funded employee welfare benefit plan.³⁹⁰ Due to financial problems associated with some of Massey-Ferguson's divisions, Varity developed a plan called "Project Sunshine" which called for the transfer of various money losing divisions and other debts to a newly created subsidiary of Massey-Ferguson called Massey Combines.³⁹¹ The plan also called for employees of the money losing divisions to switch employment to the newly created subsidiary. For those employees who ultimately accepted this proposal, Massey-Ferguson was effectively released from its obligation to provide certain benefits. In addition, Varity also unilaterally assigned to Massey Combines the benefit obligations it owed to over 4,000 workers who had previously retired from Massey-Ferguson.³⁹² Unbeknownst to the employees and retirees, Varity was aware that Massey Combines was from the start an insolvent company, and it eventually ceased operations.³⁹³ In order to sell its proposal to the employees, Varity intentionally overvalued the assets of Massey Combines, which in reality had a \$46 million negative net worth.³⁹⁴ As a result of the artifice created by Varity which resulted in Massey Combines failure, employees of Massey Combines along with the Massey-Ferguson retirees whose benefit obligations had been assigned to the newly created

Amendment's Due Process clause).

387. *Dukes*, 57 F.3d at 360-61. Interestingly, in *Pappas v. Asbel*, 675 A.2d 711 (Pa. Super. Ct. 1996) the court decided that ERISA did not preempt a hospital's third-party claim that the HMO was negligent in delaying transfer authorization for a patient suffering from an emergency condition. Plaintiff originally sued the physician and hospital for permanent injuries suffered as a result of the alleged transfer delay. *Id.*

388. 116 S. Ct. 1065 (1996); see 29 U.S.C. § 1132(a)(3) (1988) which states:

a civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a)(3) (1988).

389. *Varity Corp.*, 116 S.Ct. at 1068.

390. *Id.*

391. *Id.*

392. *Id.* at 1068-69.

393. *Id.* at 1069.

394. *Id.*

company lost significant benefits for which Massey-Ferguson would have been obligated, but for "Project Sunshine".³⁹⁵ In holding that § 1132(a)(3) did in fact allow individual beneficiaries to sue for relief under ERISA, the Court resolved a conflict that had existed among the various circuit courts.³⁹⁶ The Third, Seventh, Ninth and Eleventh Circuits had previously held that § 1132(a)(3) when applied to a claim of breach of fiduciary obligation, did not authorize awards of relief to individuals, but rather only authorized lawsuits to obtain relief for the plan.³⁹⁷ The impact of the *Varity Corp.* decision with respect to emerging liability claims arising from utilization management and financial incentive arrangements between health care providers and payers is potentially significant in cases where the facts reveal egregious conduct by plan administrators carried out in an effort to "save the employer money at the beneficiaries' expense"³⁹⁸ to such a degree that it adversely impacts upon the "quality of benefits" received by the subscriber.³⁹⁹ In *Varity Corp.* the Court may have, although unintentionally, created a legally enforceable duty of loyalty extending beyond plan asset management to individual beneficiaries, in contravention of established trust law by characterizing a denial of benefits as a breach of fiduciary duty.⁴⁰⁰

In that recent cases addressing ERISA tend to reflect a trend toward a narrowing of the preemption doctrine,⁴⁰¹ it is more than ever necessary that the responsibilities and tasks of UM departments be kept separate and distinct from those being carried out by arrangers and providers of health care. UM departments must carefully identify and document all information establishing a good faith foundation of support, to justify actions as appropriate and proper in the event a decision is later challenged. Importantly, financial incentives

395. *Id.*

396. *Id.* See *McLeod v. Oregon Lithoprint, Inc.*, 46 F.3d 956 (9th Cir. 1995); *Bixler v. Central Pa. Teamsters Health & Welfare Fund*, 12 F.3d 1292 (3d Cir. 1993); *Anweiler v. American Elec. Power Serv. Corp.*, 3 F.3d 986 (7th Cir. 1993); *Simmons v. Southern Bell Tel. & Tel. Co.*, 940 F.2d 614 (11th Cir. 1991).

397. *Varity Corp.*, 116 S. Ct. at 1069.

398. *Id.* at 1074-75.

399. *Dukes*, 57 F.3d at 355-61.

400. *Varity Corp.*, 116 S. Ct. at 1078. The Court rejected the argument of amici that the Court's ruling will result in administrators interpreting plan documents as requiring payments to individuals instead of trying to preserve plan assets. In *Smith v. Texas Children's Hosp.*, 84 F.3d 152 (5th Cir. 1996), the court, relying on *Varity Corp.*, held that ERISA did not preempt a fraudulent inducement claim asserted by a hospital's former employee arising from its alleged misrepresentations which induced the employee to unknowingly give up accrued disability benefits. *Smith*, 84 F.3d at 157.

401. See *Napoletano v. Cigna Healthcare of Connecticut*, 680 A.2d 127 (Conn. 1996). ERISA does not preempt state laws created to protect consumers (who were subscribers of managed care plan) from unfair business practices and a state law which required filing and disclosure of information concerning preferred physician provider networks. *Id.*

between providers and payers must not affect the quality of benefits received by subscribers.

IX. CONCLUSION

Although in its infancy, managed care is now a recognized part of America's health care delivery system. Recent studies reflect that the cost containment mechanisms of managed care have reduced overall health care costs and offer the potential for additional savings in the future. If managed care is to meet the many expectations that have been placed on its shoulders, it must be provided the opportunity to operate in an atmosphere free of unreasonable regulation, legislation and litigation.

